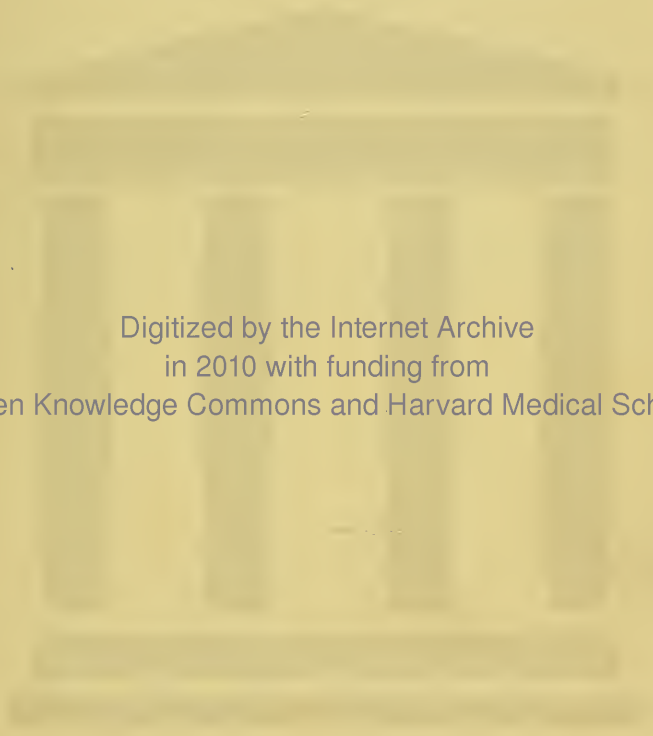




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THE NEW SYDENHAM
SOCIETY.

INSTITUTED MDCCCLVIII.

VOLUME XXXI.

CLINICAL MEMOIRS
ON THE
DISEASES OF WOMEN

BY
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Physician to *la Pitié*,

AND
M. ERNEST GOUPIL,
Late Physician to the *Bureau Central*.

(Ars tota in observationibus, sed perpendendæ sunt observationes.)

IN TWO VOLUMES.

VOL. II.

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EDITOR'S PREFACE.

THIS, the second volume of the work of MM. Bernutz and Goupil, is devoted to the consideration of two subjects, viz.:—*Pelvi-Peritonitis* and *Uterine Deviations*. The former of these has hitherto met with so little attention among English medical writers, that in many of our standard works no mention whatever is made of it. In many instances the disease is confounded with *pelvic cellulitis* or *peri-uterine phlegmon*, with which, indeed, it has little or nothing to do. Whether or no closer observation and study will show that the disease is more common than has been heretofore acknowledged, is a point which time alone can determine. Certain it is that the views here propounded have not as yet found much favour with physicians in this country. On the other hand, no one who reads the minutely detailed record of cases in the original of this volume, can doubt that the author (M. Bernutz) is a most careful and conscientious observer, and the results of the *post-mortem* examinations appear to be very conclusive as to the points at issue.

In regard to the Second Part, which treats of *Uterine Deviations*, there is much there, also, which is opposed to the experiences of English Physicians. That flexions and versions of the uterus should of themselves give rise to no symptoms, and that the signs which we have regarded as indicative of uterine displacement should be ascribed entirely to complications which

are independent of such displacement, these are doctrines which, startling though they be, are happily of such a practical character, and so far removed from the region of hypothesis and theory that their truth or error admits of very easy demonstration. All that is required, is full and fair investigation, and it is hoped that the publication of this work by the Council of the New Sydenham Society, will further the settlement of these disputed questions.

I have added to the present volume a full Index and List of References to Authors, which, I trust, will be found useful.

ALFRED MEADOWS.

GEORGE STREET, HANOVER SQUARE.

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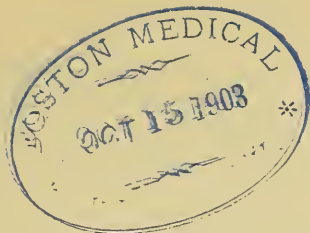
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PART I.

PELVI-PERITONITIS.

CHAPTER I.

CAUSES AND VARIETIES.

IN the two last Memoirs of the preceding volume I have reviewed the history of the several varieties of hæmorrhagic pelvi-peritonitis; in the present volume I shall consider the different kinds of simple inflammation of the pelvic serous membrane. These varieties, whether they be sero-albuminous or purulent, are invariably symptomatic affections, like those already described; as is also the metastatic variety, which I shall consider when describing the puerperal form. They are almost always symptomatic of some affection of the internal genital organs, which is, perhaps, overlooked during life, because the severity of the peritoneal symptoms masks those of the disease from which it arises. Hence it is that this group of complex symptoms has been described as belonging to a simple disease, just as in the male a similar complex group has been called by the one name *Orchitis*.*

This explains both the importance and the difficulty of the study of pelvi-peritonitis. The variety of names which have been given to this group of symptoms, engorgements of the uterus, partial chronic metritis, ovaritis and peri-uterine phlegmons; the difference of opinion on the subject, and the passionate discussions to which it has given rise, demonstrate at once the importance and the difficulty of the study of feminine orchitis. I do not think I exaggerate this difficulty, when I compare it with that which enveloped the subject of pleurisy before the discovery of auscultation; nor do I con-

* Rochoux, *Archives générales de médecine*, 2^e série, 1833, t. ii. p. 51.

sider that I exalt its importance too much in saying that the future knowledge of uterine pathology is as certainly subordinate to an acquaintance with this affection, as pulmonary pathology has been to a complete knowledge of inflammation of the thoracic serous membrane.

These facts in pathology have, during the last twenty years, caused a great deal of discussion; and various names have been given to them, according to the importance attached by authors to one or other set of symptoms. The impartial analysis to which I have subjected them has led to a most unlooked-for conclusion, as will be apparent hereafter. One of the names by which this disease has been designated is *engorgement of the uterus*; a title which reminds one of that of "fluxions of the chest," by which pleurisy was once designated. Though this term is now too vague to be of any value, it is of use as indicating a service rendered to uterine pathology.

The term *partial chronic metritis*, which soon followed the former, represents another step in advance. *Peri-uterine phlegmon* is another name which was unhappily selected by M. Nonat;* and, although it involves a fundamental error, yet it indicates a further advance in the pathology of the disease; it shows that the swelling which existed was unconnected with the uterus, as had been thought to be the case till the researches of Recamier† and Nonat.‡ The importance of this distinction, which M. Nonat very properly insists upon, appears to me such that the title *peri-uterine phlegmon* deserves a place in the history of this affection. Before entering further on the consideration of my subject, I must make a few critical remarks upon the term *peri-uterine phlegmon*, inasmuch as it is still employed by certain practitioners, who believe, as I did for some time, that it rests on sound anatomical data. I reject this term, however, because it is at once true and false—true, for the term *peri-uterine*; false, for that of *phlegmon*. I shall leave the proof of the second part of this proposition to a later stage of the discussion; and, as the establishment of the first requires a description of the normal anatomy of the parts, I shall proceed with this first. This consideration convinces me that the various inflammatory swellings, so-called *peri-uterine phlegmons*,

* Nonat, *Thèse inaugurale*, de M. Martin. Paris, 1851.

† H. Bourdon, *Tumeurs fluctuantes du bassin* (*Revue médicale*, 1841).

‡ Nonat, *Observ. méd.* (*Gazette des Hôpitaux*, 1850.)

(ante- retro- and latero- with their hybrid varieties) cannot be located in the cellular tissue between the uterus and peritoneum. The disposition of the cellular tissue on the anterior and posterior surfaces of the uterus, as well as that on its sides, is proof against this. The slightest dissection shows that the cellular tissue subjacent to the peritoneum is so thin and scanty that it is impossible to separate the serous from the uterine tissue; and that, consequently, it cannot be the seat of swellings which, according to M. Nonat's observations, attain in the space of a few hours to the size of a hen's egg. The only other possible position for these so-called ante- and retro-uterine phlegmons is the small band of cellular tissue situate at the junction of the neck with the body of the uterus; and this we can hardly credit, unless it be proved by an undoubted post-mortem examination, which has never yet been adduced.* In the absence, then, of direct proof, I may be allowed to doubt the existence of this affection as described by M. Nonat.† I have for four years asked for proof of this proposition;‡ and, as no one has yet been able to give it, I shall assert that the swellings we are now considering are certainly not formed by the inflammation of the thin ring of cellular tissue which encircles the upper portion of the neck of the uterus. In the exceptional cases where this tissue is involved in the inflammation of the surrounding parts, it but very slightly augments the peri-uterine swelling, and this only where there exists also pelvi-peritonitis.

We may now pass on to the consideration of the position occupied by the latero-phlegmons, and determine whether it is possible, on anatomical grounds, that phlegmons of the broad ligaments may co-exist with peri-uterine latero-phlegmons—two perfectly distinct affections; in a word, whether it be possible that the swellings characteristic of two dissimilar affections can co-exist in the tissues in the lateral part of the uterus. Careful dissection has shown me that the cellular tissue subjacent to the peritoneum is only separable from those parts (the peritoneum and uterus) at about 4-5ths of an inch from the lateral borders of the latter, and it is only where it joins the broad ligament that it has any appreciable thickness. Hence there is no cellular tissue lateral to the uterus, except just that which enters

* Gallard, *Thèse inaugurale*. Paris 1855.

† Nonat, *Traité des maladies de l'utérus*, pp. 686 to 794.

‡ Bernutz et Goupil, *Arch. gén. de méd.*, mars et avril, 1857.

into the structure of the broad ligament; this is circumscribed below by two folds of aponeurosis mentioned by M. Jarjavay;* above by a thin aponeurotic lamella, which is described below by my coadjutor,† from which it appears that, joined by the posterior fold of aponeurosis, this thin lamella is carried forwards below the folds of the broad ligament, and becomes united with the anterior aponeurotic fold. Hence it results that the progress of the inflammation of the cellular tissue almost necessarily tends towards the abdominal

* Jarjavay, *Anatomie chirurgicale*, t. ii. p. 596.

† When we dissect the broad ligament, it is easy, by beginning at its lowest part, to unfold its two portions separating the muscular and serous layers which constitute the external envelope, and the aponeurosis described by Professor Jarjavay; but when this is accomplished from below, and the upper part is reached, our progress is arrested by a thin aponeurosis, which completely separates the parts or organs contained in the ligament, viz., the tubo-ovarian apparatus, and the round ligament. If, then, we lift the peritoneal layer along the upper border of the broad ligament, which is not at all difficult, except at the middle of the ovary, and a part of the Fallopian tube, we find that, underneath the peritoneum, there is a very thin aponeurotic layer, which precisely resembles the layer found on the lower part. These two layers constitute, as it were, the fibrous *frame* of the upper border of the broad ligament, and determines its shape. They enclose the ovary and its ligament, the Fallopian tube, the utero-ovarian vessels, and the muscular tubo-ovarian apparatus described by Professor Rouget. On the outer side of the Fallopian tube these two layers unite, and are only separated by some small vessels which surround the round ligament, and become blended with the anterior aponeurosis of the broad ligament, just as behind they are blended at their origin with the posterior aponeurosis. By their internal border, they may be traced as far as the superior angle of the uterus and its anterior border, while externally they become one with the iliac fasciæ.

These aponeurotic layers vary a good deal in different subjects. These points have been attested by my colleague, M. Lefort, Prosector to the Faculty, who has demonstrated them by some beautiful dissections and injections. I do not wish to attach any undue importance to them; but their existence enables us to understand how abscesses of the broad ligaments developed in their cellular tissue are situated below this aponeurosis, below the Fallopian tube, and in front of the ovary; while, on the contrary, the purulent collections formed in the cases of pelvi-peritonitis which we are considering are intra-peritoneal lesions, connected generally with affections of the tube or ovary, and situate behind, and external to the layer of aponeurosis, which I am describing. In these affections, the sub-peritoneal cellular tissue shares the same fate that the sub-pleural does in pleurisy; it becomes harder, and more friable, so that dissection of the serous layers and subjacent parts become more difficult, if not impossible.

walls, or else to the deep iliac fossa. Hence phlegmons of the broad ligaments are justly so called,* and they ought to be studied with phlegmons of the iliac fossa, of which they are a very interesting variety.

It is not here a question of phlegmons of the broad ligaments. These affections are undoubtedly located in the cellular tissue of the lateral parts of the uterus, as numerous autopsies have testified.† It is therefore anatomically impossible that the tumours which M. Nonat called uterine latero-phlegmons, and which are quite distinct from phlegmons of the broad ligament, can be situate in the cellular tissue of the lateral parts of the womb.

For some time I had no idea that the view propounded by M. Nonat was a mere hypothesis which rested on no *post-mortem* evidence. And it was not till after the unfortunately fatal termination of two cases, that I was able to prove incontestably that the peri-uterine tumour which, during life, presented all the symptoms of the so-called peri-uterine phlegmons, was not situate in the cellular tissue at all. In the autopsies in question, the tumour, which even after death presented all the usual signs, was seen to be formed by the pelvic viscera being matted together by peritoneal adhesions; so that I am justified in contradicting the hypothesis of my honourable colleague at *La Charité*. This discovery upsets all our previous convictions, and teaches us not to accept as our starting-point the symptomatology of engorgement of the uterus.

These researches, then, have led to the conclusion that inflammation of the pelvic peritoneum, which is the cause of the visceral adhesions, is a disease very commonly met with. I find also that the tumour found after death is formed by various intra-pelvic viscera being matted together as a consequence of the inflammation; and thus, that feminine *vaginalitis* ‡ is nosologically as important as orchitis in the male. Lastly, I conclude that inflammation of the pelvic serous membrane is always symptomatic, and that it is generally symptomatic of inflammation of the ovaries or Fallopian tubes. Thus great interest attaches to the study of this affection; and it is very important thoroughly to understand the symptoms, in order to describe satisfactorily the uterine, and more especially the tubo-ovarian diseases which occasion it. To do this, we must compare carefully

* Grisolle, *Arch. gén. de médecine*, 1839, 3^e série, t. iv. p. 34, 137, 293.

† Marchal (de Calvi), *Thèse d'agrégation*. Paris, 1844.

‡ (By this term is meant, inflammation of the tunica vaginalis. Ed.)

the lesions found after death with the symptoms observed during life ; and this comparison has led to the belief that in the symptomatology of false peri-uterine phlegmons, the majority and the more important of the symptoms are attributable to pelvi-peritonitis ; while the uterine or tubo-ovarian affection, although of much more importance, is indicated only by obscure symptoms.

It follows from all this, that unless we get fatal cases to enable us to determine anatomically where the pelvic inflammation began, we cannot state positively whether it came from inflammation of the ovary, or of the Fallopian tube ; nor whether it was caused by the puerperal state, by blenorragia, scrofula, or any other malady. Thus we can only lay hold, as it were, of the two ends of the pathological problem, the primary disease and the serous inflammation—the intermediate gap we can only fill up after death.

The following case I have already published in 1857 ; and I give it now at some length, because it is important in a controverted subject to give as many details as possible. Those, however, who care not to read the cases entire may consult the headings only which are attached to each case.

CASE I.—*Blenorrhagia of the urethra, vagina, and uterus ; twelve days afterwards, severe pain over the lower part of the body. Admission into the Hospital on the twentieth day, when a swelling round the cervix was discovered.—Pleurisy.—Death.—Autopsy ; extensive peritonitis ; between the left broad ligament, and the sigmoid flexure, adjoining the ovary, which was quite healthy, was a collection of pus in the peritoneal cavity.—Right ovary healthy.—Purulent collections in the right tube ; obliteration of the left.—Sub-peritoneal cellular tissue of the uterus and broad ligaments quite healthy.*

A young woman, aged 18, was admitted into *Lourcine*, February 12th, 1856. Her mother died of phthisis. Has always enjoyed good health. Menstruation began at 15 without pain, and has been regular since. She had sexual intercourse for the first time on the 10th of February, 1855, and since then has only menstruated three times, viz.: in February, July and December ; in all other respects she has been in good health, till the venereal attack for which she was admitted into Hospital. From the 20th to the 25th of January, she had sexual intercourse with a man who was under treatment of some kind at the *Hôpital Midi*. After this she had a greenish discharge ; but still she felt well till the eighth day, when

she was seized with sharp pain in the lower part of the body, which was increased by movement and defæcation; these continued to increase, and for them she was admitted into *Lourcine*.

Examination of the mouth showed no sign of past or present syphilis; she complained of great pain across the lower part of the stomach, especially to the left; it was increased by movement and defæcation. The anus and external genitalia were healthy. The meatus and inner surface of the labiæ minora were very red, as was the whole vaginal canal and surface of the cervix. A purulent, sometimes glairy mucous discharge issued from the cervix. The cervix itself was small, conical, soft, and normal in direction. A resisting body was felt in the anterior cul-de-sac, perpendicular to the cervix; it occupied also the posterior and left lateral culs-de-sac; and, indeed, existed all round the cervix, except on its right side, as is represented in the annexed sketch, Fig. 1.

In the right vaginal cul-de-sac, a groove of separation could be felt between the cervix and the tumour. Pressure on this tumour, on its left and posterior parts, caused great pain in the abdomen, similar to that experienced by the patient in moving, etc. Ordered fifteen leeches to the left iliac region, rest, etc. This gave some relief, and the redness was slightly diminished; the tumour, however, remained as before—

perhaps the groove of separation was more distinct. By rest, in a few days, there was some further improvement. Then again, the iliac pains returned, and any examination increased the suffering, the discharge increasing with it.

Early in March she had an attack of jaundice—then symptoms of pleurisy on the right side, ægophony, etc. These symptoms increased in severity, accompanied with great dyspnœa; paracentesis thoracis was accordingly performed, and an enormous quantity of fluid was drawn off, but without any appearance of pus or lymph. This gave great relief, but only for a few days; the chest refilled, and was again tapped—this time the fluid was purulent. Iodine was therefore injected, but this failed to prevent a repetition of the effusion. Tapping was accordingly repeated for the third time, but the patient sank, and died on the 12th of May.

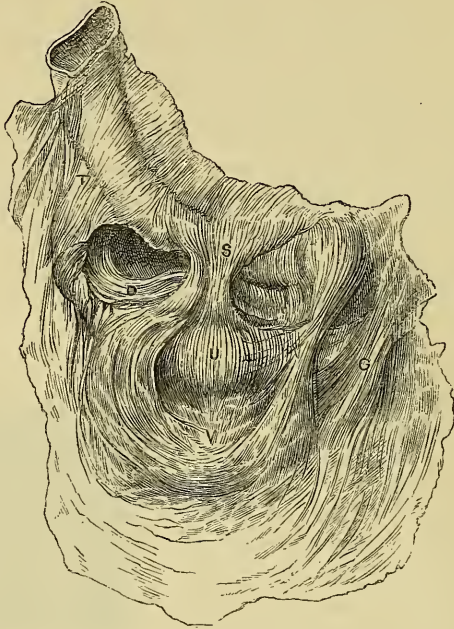
Post-mortem examination—On opening the abdomen, the bladder

FIG. 1.



uterus, broad ligaments and sigmoid flexure were all bound together by old firm adhesions, as is represented in the annexed sketch, Fig. 2.

FIG. 2.



The posterior surface of the bladder, v., was united to the uterus, u., by two bands of adhesions—one of which passed on to the sigmoid flexure, s., the other united also the Fallopian tube, t., to the sigmoid flexure. Between these two vesical bands, the vesico-uterine peritoneal cul-de-sac was healthy. The right broad ligament, d., covered by the membrane from the bladder, formed, as it passed behind the border and right angle of the uterus, a *demi-involucre*, which constituted the upper and internal wall of the pelvic cavity of that side. All this peritoneum was covered with false membranes. On the left there was no pelvic cavity, the broad ligament was united to both bladder and rectum; on quietly separating these adhesions, an intra-peritoneal abscess full of pus was opened; it was situated in front of, and below the ovary, being in direct contact with the peritoneum covering that viscus. The uterus itself was bound posteriorly to the rectum, but was also acutely anteflexed.

The Fallopian tubes were highly congested. The right contained

two small purulent collections, one at the fimbriated extremity, which was dilated and firmly adherent to the ovary. The left tube was impermeable, but contained no pus. The ovaries were both healthy. The cellular tissue of the broad ligaments and uterus was perfectly healthy.

In this case, a person, who had hitherto been entirely free from abdominal pain of all kinds, is suddenly seized on the 12th day of an attack of acute blenorragia, with an intra-pelvic affection, the nature of which is apparent from the symptoms and *post-mortem* appearances. In short, the co-existing disease, the extent of the blenorragia, involving, as it did, not only the vagina and uterus, but even the Fallopian tubes; and, lastly, the period at which the abdominal pains began—all these point to an affection analogous to that of orchitis in the male, produced by the extension of inflammation from the external to the internal parts, which became evident when the fimbriated extremity, which is the analogue of the epididymus in the male,* was reached.

This opinion seems to be confirmed by the fact, that an intra-peritoneal collection of pus was found in contact with the left ovary; this was probably caused by the escape of some pus which had existed in the left fimbriated extremity, which was now empty; while the pavilion of the opposite tube was distended with pus.

I shall not now dwell further on this point, because I intend to point out the differences which exist in these analogous affections in the two sexes; differences which are due, first to the large extent of pelvic peritoneum, representing in the female the double tunica vaginalis of the male; and, secondly, to the absolute independence of this pseudo tunica vaginalis from other parts of the peritoneum. Thus we see that the signs of vaginalitis, which in man constitute the prominent feature of the symptoms of orchitis,† are replaced in the female by symptoms of partial peritonitis.

The adhesions observed in the case just described deserve particular attention; because, in comparing the sketch made of the *post mortem* appearances with the notes of the examination made during life, I was greatly surprised at the striking resemblance between them.

It was especially noticed—first, that the only part of the pelvic

* Postello, Medicinæ in Academia Cadoneni professor, *Acta Eruditorum Lipsiæ*, t. iii. p. 40 (1692).

† Rochoux, *Archives générales de médecine*, 1833, 2^e serie, t. ii. p. 51.

cavity, which was free from all adhesion, corresponded exactly with those parts where no resistance could be felt during life. It is also to be observed, secondly, that the several points in the examination during life found their counterpart in the four groups of adhesions observed after death. First, the adhesions of the different parts of the right broad ligament with itself. Second, the adhesions of the anterior surface of the anteflexed uterus with the bladder. Third, the adhesions of the left broad ligament with itself, with the rectum, and with the sigmoid flexure; and, Fourth, the adhesion of the posterior surface of the uterus with the sigmoid flexure. It is further to be noted, that in the rough sketch made during life, the form of the right anterior cornu of the supposed phlegmon represents the form of the twisted right broad ligament. The border of the anterior middle part represents the anterior border of the upper surface of the anteflexed uterus, and the left part of the sketch represents the reniform mass of the left broad ligament, the hilum of which is occupied by the border of the uterus, and in front of this were the utero-rectal adhesions which represent, in the sketch, the posterior part of the supposed phlegmon.

The last sentence shows how we were deceived when, after having minutely dissected all the organs united by adhesions, we were compelled to acknowledge that the cellular tissue of the uterus and its appendages, so far from being the seat of the peri-uterine induration, was, on the contrary, exempt from the inflammation of the organs which it covered. It was healthy in the right broad ligament—it was normal on the anterior surface of the uterus; but, on the left side, where the purulent collection existed, it did not appear, at first sight, at any rate, to be so. But it was evident that the purulent collection existed between the anterior surface of the sigmoid flexure, and the posterior surface of the left broad ligament, and was encysted by false membrane. It was thus manifestly intra-peritoneal; and could not, therefore, be regarded as a lesion of the proper cellular tissue of the left broad ligament. Thus, we may also remark, that even in the left part of the peri-uterine tumour, no proof was found of the existence of a true phlegmon—since the lesions which then existed, were due to the blenorrhagic inflammation of the tube, and to the neighbouring peritonitis.

The same remarks apply to the posterior part of the peri-uterine tumour, which equally presented no trace of induration of the cellular tissue of the posterior surface of the uterus—indeed, this forms normally so thin a layer, that it seems impossible that it could

ever be the seat of a retro-uterine phlegmon. Thus, the morbid resistance, which, during life, was felt behind the cervix, could not be ascribed, after death, to induration of the cellular tissue, for this was healthy. Indeed, the dissection proved that the resistance was due to numerous peritoneal adhesions, which existed between the uterus and the sigmoid flexure, and to the thickening which was found in the sub-serous cellular tissue of the anterior surface of the rectum. As to the pathological signification of this last inflammatory lesion, it offers no objection to my theory, because it did not belong to the cellular tissue of the genital organs; it seemed, indeed, to be due to its contiguity to the purulent collection, and indicated a curative attempt to give issue to the matter per rectum.

I need not dwell on this point, nor need I stay to discuss the influence which either the purulent collection or the blenorrhagia may have had on the development of the fatal hydro-thorax. I make no remark on the healthy condition of the ovaries; nor, on the contrary, on the morbid condition of the tubes, which shows the close resemblance which exists in cases of blenorrhagia in the two sexes. I hasten on to the following case, in which a series of phenomena, analogous to those which I have just analysed, arose after some disturbance of menstruation, though the circumstances which originated the peritonitis differed widely in the two cases.

CASE II.—*Menstrual suppression; development of spurious peri-uterine phlegmon, leading to successive uterine deviations. Death from malignant small-pox. Autopsy; uterine deviations; peritoneal adhesions between the uterus and rectum; inflammation of the tubes; peri-uterine cellular tissue healthy.*

A young woman, aged 19, was admitted into *Lourcine*, Jan. 30, 1855. Menstruation began when she was 16, with pain, since which time it has occurred every three weeks, lasting from two to six days. A year ago she had an easy labour with her first child. Six months ago she contracted a venereal discharge, for which she was treated in the hospital for two months; she then went out, and again had sexual intercourse. Fifteen days after she noticed ulcerations on the external genitals; these, after some time, gave place to papules, which were very painful to the touch.

When admitted on the 30th Jan., numerous mucous tubercles existed over the external genitalia. The vagina was very red, and there was a good deal of discharge. The uterus and vaginal cul-de-sac were quite normal. Ordered mercurial treatment.

February 2nd. Menstruation came on but scantily. Meanwhile the syphilis was improving, under the influence of the proto-iodide of mercury. On the 13th, she had a rigor, followed by severe pain in the right iliac fossa, which was increased by movement. On the 17th, the severity of the symptoms had greatly increased; pulse small, 108, respiration frequent, sighing, pressure on the right iliac fossa gave great pain. There was some tumefaction to be felt there in the region of the right broad ligament. No tenderness or fulness in front or on the left side. The vagina was hot in the posterior and left lateral culs-de-sac. Behind the cervix, which was normal, but directed in front and carried up high behind the pubis, a round, resisting, and very painful non-pulsating tumour was felt. The anterior cul-de-sac was free in the posterior part of the right cul-de-sac, and in the left cul-de-sac a vague resistance could be felt. Fifteen leeches were ordered to the left iliac region, rest, &c.

On the 18th, while in a bath, after the application of leeches, she experienced a smart loss of blood, which she attributed to menstruation, the period having before been scanty. She felt rather better for it than otherwise.

On the 19th she was in much pain; pulse, 120; pain increased by the slightest movement or coughing. Examining the right iliac fossa, a painful tumefaction was felt there, in the situation of the broad ligament.

On the 20th she was somewhat relieved, but still feverish and thirsty; there was a good deal of white discharge; the vaginal swelling was less in size, and not so hot as before. Ordered to continue the treatment by baths, saline draughts, poultices, &c.

During the next four days, though she continued to improve, she had several short rigors, followed by heat of skin, thirst, &c. There was less pain and swelling in the iliac fossa; the cervix and body of the uterus, instead of being as before against the pubis, were now carried back to the posterior cul-de-sac, where a sort of hard vertical band could be felt apparently attaching the uterus to the anterior wall of the rectum. The discharge was less abundant, white, and inodorous.

On the 22nd it was noted that, in addition to the slight lateral version, the fundus of the uterus was somewhat depressed backwards, and the cervix forwards.

Matters continued very much in this condition up to the 18th of April, when, without any apparent cause, she was seized with a rigor, followed by smart fever, heat of skin, acute pain in the back

and iliac fossæ, especially the left, much increased by pressure. No tumefaction could be felt anywhere.

On the 22nd pustules of variola appeared, and these soon became filled with blood:

On the 27th she suddenly and unexpectedly died.

At the *post-mortem* examination, slight gangrene of the left lung was observed, with some lobular pneumonia. The uterus was pushed on to the rectum, to which it adhered; the fundus being towards the left, the cervix to the right; no adhesions with the bladder. There was no flexion of the uterus, its mucous lining was healthy, its peritoneal covering, especially posteriorly, was much thickened; on attempting to detach this from the uterus, it was found that though it could easily be done from below up to the junction of the cervix and body; yet, beyond that part, and all over the fundus, it was impossible. Beneath the peritoneum was a thin layer of cellular tissue, which became thicker the nearer it approached the broad ligaments, with which it became incorporated. On the left Fallopian tube was a thin layer of false membrane; both tubes were somewhat larger, injected, tortuous, and seemed under the finger firm, full, and cord-like; their fimbriated extremities were firmly adherent to the ovaries, and their calibre in this direction notably increased in size—the left contained some thick, plum-juice coloured fluid, but no clot; the right the same, but less in amount. The ovaries contained no clots or corpora lutea; their tissue was firm, thick, and covered with numerous cicatrices.

The remarks which I have made at the end of the first case, render it unnecessary for me to discuss the particulars of the second; but I may observe, that in this case the symptoms of acute peritonitis were, from the first, very plainly marked, and the subsequent progress of the case showed the changes which took place in the organisation of the false membranes by the successive displacements of the uterus. We may also dismiss the question of the existence of a retro-uterine phlegmon previous to the peritonitis, inasmuch as the cellular tissue on the posterior aspect of the uterus was normal. I have already referred to the extreme tenuity of that cellular tissue, both on the anterior and posterior surface, and this alone ought to raise a doubt as to the soundness of the theory of ante- and retro-uterine phlegmons in regard to their anatomical relations.

In this case, more than in the first, notwithstanding the relation which we have established between pelvi-peritonitis and orchitis, it

may be doubted whether these affections of the pelvic serous membrane can convey a sensation analogous to that of a phlegmon, unless the peri-uterine cellular tissue participates in the neighbouring inflammation. It is so rare to meet with a fatal termination in the acute stage, that we cannot hope for some time to come to dissipate the doubt entertained by some in this respect; but my excellent friend, M. Bouchet, has just had a case of this kind. This patient I saw during life, and examined after death, the autopsy being made in the presence of M. Aran, who certainly was not prepossessed in favour of my opinion, seeing that he has not yet been able to reject entirely the existence of supposed peri-uterine phlegmons.

CASE III.—*Menstrual suppression from cold on the 8th day of menstruation, followed at once by vomiting and severe abdominal pain. —On the 16th a retro-uterine tumour was discovered, resembling a hæmatocele, except that it was far less fluctuating. —General peritonitis; death in twelve days. —Autopsy. —Purulent lymph in the abdomen; pelvic cavity encysted and containing a good deal of puriform serum. —Pus in the Fallopian tubes; cavity of uterus dilated and filled with a muco-sanguinolent fluid. —Cellular tissue of the broad ligament, of the uterus, and of the retro-uterine cul-de-sac perfectly healthy.*

A young woman 22 years of age, was admitted into the *Hôpital Saint Antoine*, January 1st, 1859. Always had good health. Has had no children. Menstruation always regular, lasting eight days. It began on the 22nd of December, continued to the 27th, and then stopped from a chill, followed by severe abdominal pain and vomiting.

On admission she complained of a good deal of pain across the lower part of the body, which was extremely tender. No tumour or swelling discovered on vaginal examination. Some fever, constipation, no vomiting. Ordered twenty-five leeches, poultices, rest, and light diet. On the 2nd twenty leeches were ordered, bath, poultices, and castor oil. Next day she was much worse, more pain and tenderness, vomiting, pulse 120. Behind the cervix a swelling could be felt, soft, semi-elastic, painful to the touch. This swelling is represented in Figs. 3 and 4, T. Ordered mercurial treatment

On the 4th, still worse. On the 6th, still in great suffering, anxious. The uterus was found pushed against the pubis, low down, and compressed by a swelling, which squeezed it from behind against the pubis in front. This swelling seemed to occupy all the pelvic cavity. The axis of the uterus was not changed. The examination

caused great pain, though less than might have been expected from the appearance of the patient and the great abdominal tenderness. The tumour in the vagina had all the appearance and feel of a semi-fluctuating hæmatocele; pulse 120. Ordered calomel, poultices, and friction of Neapolitan and belladonna ointment.

On the 7th she was worse, more pain and tenderness; vomiting diarrhœa; pulse 124. Ordered to repeat the frictions, opium, baths, &c. Next day she was worse still, had a rigor, delirium, prostration, great abdominal pain and tenderness. Cervix pushed more firmly

FIG. 3.

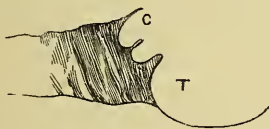
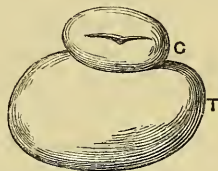


FIG. 4.



C represents the cervix, and T the tumour.

against the pubis by the projecting tumour behind, which was semi-fluctuating and tender; pulse small, 120. She died at 11 A.M.

Autopsy forty hours after.—No sign of decomposition. On opening the abdomen a good deal of thick, serous fluid came away. The intestines were adherent to the fundus uteri and broad ligaments, and closed over the posterior cul-de-sac, which was distended with purulent serum. No blood or altered blood was found. *The cellular tissue, especially that in the vagino-rectal cul-de-sac was perfectly healthy.* The uterus itself tolerably healthy, but its mucous lining was injected; *the sub-peritoneal cellular tissue was quite healthy,* as also that of the broad ligaments. Ovaries healthy; Fallopian tubes firmly adherent to them, tortuous, and somewhat enlarged; the fimbrium of the left tube was inflamed, and contained some thick, creamy pus; which also existed throughout both tubes.

I shall not make any remark on this very interesting case; which is all the more valuable, in my opinion, because it was not recorded by me, but by a very impartial and distinguished friend of mine, who is entirely free from any bias on this question. I will only add, that the tardy appearance of the peri-uterine tumour, viz., on the seventh day, and the absence of any clot or blood product, either in the pelvic cyst or in the uterine appendages, completely refutes the idea of its having been a suppurative hæmatocele. I

need not say that the absolute integrity of the peri-uterine cellular tissue maintained by my colleague, M. Aran, who still admits the possibility of peri-uterine phlegmons, the short duration and gradual aggravation of the affection, forbids the belief that the cellular tissue was the seat of an inflammation which had reached its complete resolution at the time of the autopsy. I think, also, that this case shows very clearly that pelvi-peritonitis, when it gives rise to an encysted collection of fluid, assumes all the characters of a retro-uterine abscess. It is difficult to believe that the same obtains in the more chronic forms of this affection, or that the symptoms of a phlegmonous tumour can be produced by the intestines being bound together by old standing adhesions. To make this matter clear, I shall quote the following painfully convincing case from the *Philadelphia Medical Examiner*:—*

CASE IV.—*Gastrotomy for a supposed tumour of the ovary, which turned out to be a mass of intestine united by adhesions.*

A woman, 23 years of age, mother of four children, the subject of syphilis, had suffered seven or eight months from a tumour in the left side of the abdomen, the size of an adult head, moveable, dull on percussion. It did not give rise to much inconvenience, but still she desired its removal, because she said her sister had died of the same thing. Four physicians to the Philadelphia Hospital recommended its removal. An incision was made about five inches long, and then it was discovered that the tumour in question was simply a collection of intestines bound together by old adhesions. The patient made a good recovery.

The details of this case speak for themselves. They prove unmistakeably that the intestinal coils, united by old peritoneal adhesions, may so perfectly simulate a tumour containing fluid, that four physicians to a large Hospital agreed, after consultation, on the strength of that impression, to resort to a most formidable operation; and this was even commenced before the error was discovered. It was actually necessary that the anatomical relations of the tumour should be made out by an operation, in order to prove that the sensation of a cyst was created by an agglutinated mass of intestines: just as in

* *Dublin Medical Press*, April 18, 1855, p. 246, and *Gazette Hebdomadaire*, July 27, 1855, t. ii, n° 30, p. 556.

my first case it was necessary to make a minute dissection of the pelvic tumour, notwithstanding that it was on the table, to demonstrate that the sensation of a peri-uterine phlegmon perceivable during life was produced in a similar manner. What I have just said shows how easily one may make an error in the diagnosis of peri-uterine tumours, and how where *post-mortem* examination is impossible the signs of partial peritonitis may be mistaken for those of spurious peri-uterine phlegmon. The mistake is easily explained, when we remember that the existence of peri-uterine phlegmons has been hypothetically established by the signs furnished in the examination of an elastic peri-uterine tumour. Still more is this error accounted for by the fact, that all other symptoms have been, as a rule, subordinated to the evidence obtained by digital examination.

But, before discussing the existence of chronic or sub-acute phlegmons, it may be well to relate a case completed by an autopsy, which may justly be regarded as a type of these spurious sub-acute paroxysmal phlegmons. The greater part of the following case has been recorded by my esteemed colleague M. Nonat; and in this very interesting history, notwithstanding the continuance of great pain, and the existence of arterial pulsations, which seemed important, the *autopsy* showed no lesion whatever of the peri-uterine cellular tissue. On the contrary, there was evidence of peritoneal lesions, similar to those which have been already described.

CASE V.*—*Hysteria; dysmenorrhœa; pregnancy; tedious labour, followed by metro-peritonitis, first acute, then chronic; recurrence of acute symptoms with menstruation five months after; suppuration and escape of matter per rectum; followed by peri-uterine phlegmons; retroversion, treatment by uterine re-dresser; which induced recurrence of hysteria, with pelvic pains, and the formation of peri-uterine tumours; accession of phthisical and recession of uterine symptoms; death fifth year after the labour, which was the starting point of the malady. Autopsy: tubercular disease of lungs and intestines; peritoneal adhesions of all the pelvic viscera; tubercular disease of the ovaries; cellular tissue of uterus and broad ligaments healthy; dilatation of the vessels of the broad ligaments.*

M. S. B., aged 24, was admitted into *La Pitié*, January 15th, 1853, having been ill for one year. In childhood she was subject to epilepsy, and at 19½, when menstruation began, she became subject

to hysteria; menstruation was very painful, and there was a good deal of leucorrhœa.

At 22, after a difficult labour, she had an attack of metritis, for which she was twice locally bled with twenty leeches. Five months afterwards menstruation returned, with a good deal of abdominal pain.

In 1852, she came under the care of M. Valleix, suffering from extreme exhaustion from diarrhœa; an abscess formed in the pelvis, and opened spontaneously per rectum. Subsequently, she came under the care of M. Nonat, who treated the peri-uterine swellings with local and general depletion. Then, again, she was attended by M. Valleix with leeching, blisters, opiate poultices, etc. Fearing a retro-version, M. Valleix applied his uterine re-dresser. This was followed by abdominal distension, by considerable hæmorrhage and severe pain. After three days the instrument was withdrawn, in consequence of an hysterical attack. Then it was re-applied, and again withdrawn for the same reason. Subsequently, she came under the care of M. Gendrin for violent hysterical attacks, which he treated with cold baths and anti-spasmodics. Again M. Nonat had her in charge, when he found decided retro-version, enlargement of the cervix, and a hard, solid, painful swelling in the iliac fossa. In the right broad ligament was a swelling the size of a hen's egg attached to the uterus, very tender; a similar, but smaller tumour existed on the left. She was treated with leeches, blisterings, and purgatives; the former were repeated again and again. She improved locally; but the hysterical attacks were very severe, especially when near the periods. All treatment was then discontinued for a time, as it was found that she could control the attacks if she chose. The tumours still diminished in size, though slowly. Symptoms of phthisis now began to show themselves; and, in August, 1856, she was admitted into *La Pitié*, under the care of M. Bernutz, suffering from acute tuberculosis, and amenorrhœa of seven months.

On examination the cervix was small; the uterus normally placed and fixed by surrounding adhesions. This condition of things continued, the patient getting gradually weaker, till about the 12th of December, when she was taken with a severe pain in the right iliac fossa; it was increased by pressure externally, but not internally, and the parts then remained about the same. The diarrhœa continued, however, and she sank December 25th, 1856.

Post-mortem examination.—Brain healthy; lungs tubercular;

abdominal peritoneum, with the exception of two old adhesions, healthy. Evidence of tubercular ulceration in the bowel, especially in the cæcum. In the pelvis, the anterior or vesico-uterine cul-de-sac was shorter than usual, owing to adhesions in those parts. The peritoneum covering the anterior surface of the uterus was opaque, 1-26th of an inch thick, doubled externally by a cellular fold from the right border of the epiploon, which, after adhering posteriorly to the left angle of the uterus and anteriorly to the bladder, dipped down to line the anterior cul-de-sac. On the right side, this epiploic extension stretched across so as to form a kind of fibro-cellular bed in which the cæcum rested. This bed was hollowed out into five grooves of unequal depth, the larger of which formed by the posterior layer of the broad ligament presented this peculiarity, that through its fine transparent texture, a small cyst could be seen interposed between the ovary and the sinuosity of the Fallopian tube. Its posterior border was united to the right angle of the third curve of the sigmoid flexure by lamellated cellular tissue, beneath which was a small pyramidal cavity, which represented the recto-uterine cul-de-sac. In this cavity was seen a very small portion of the right posterior aspect of the uterus free from all adhesions. All the left posterior aspect of the uterus was adherent to the rectum; but this adhesion was not the cause of the retroversion. The uterus itself was slightly twisted round to the right, owing to the tumour which occupied the left broad ligament.

The left broad ligament was covered with peritoneal incrustations, caused by its union with the epiploon and sigmoid flexure, which obliterated the left pelvic cavity.

The dissection revealed no induration in the sub-peritoneal cellular tissue of the anterior and posterior aspects of the cervix; but on the body of the uterus, this tissue, if it existed at all, could not be discovered, notwithstanding the thickness of the peritoneum. The uterus itself was fairly normal.

The left tube was much curved, permeable, and contained some thick creamy fluid; the mucous lining healthy, and the pavilion firmly adherent to the ovary.

The right tube presented an analogous condition; we could trace its cavity up to the uterus, but then lost it. Between it the uterus and the ovary was a small transparent cyst the size of a hazel nut.

Both ovaries contained crude tubercles, just like those met with in the testicle. The round ligaments were healthy.

The most careful dissection failed to discover any induration in the cellular tissue of the broad ligaments. The only point noticed was the large size of the vessels there, which formed a considerable plexus at the base, each vessel being quite double its normal size. Two ulcers, of a tubercular character, existed in the rectum.

In this case, after what M. Puzos calls a milk abscess, we find a long continuance of pelvic pains and peri-uterine swellings, similar to those which I observed in my first cases; and, as in these, the only lesions found after death were peritoneal adhesions and an ovarian affection, but no sign of any antecedent inflammation of the cellular tissue, either of the broad ligaments or of the uterus. I believe, therefore, that I am right in concluding that this patient, like the former, was suffering from chronic peritonitis, the products of which simulated phlegmonous tumours.

To this peritonitis I would ascribe the continuance of the pain which the patient suffered, and which was increased by slight causes, especially by menstruation. I agree with M. Gosselin,* that peri-uterine phlegmons run a special course, very different to the inflammation of cellular tissue elsewhere; and that they deserve the name of sub-acute recurrent phlegmons. This pathological anomaly, like that incidental to chronic phlegmons, disappears when we attribute to peritonitis the symptoms of spurious peri-uterine phlegmons. There is then nothing abnormal in their progress, the intermittent character of the acute symptoms which often takes place becomes, as it were, natural; inasmuch as chronic inflammation of serous membranes, and especially of that in the pelvis, is characterised by these exacerbations.

Important, however, as is this pelvi-peritoneal inflammation, it is not the less secondary. In my first case, it occurred after an attack of blenorragia, which had successively involved the uterus and Fallopian tubes; in the second and third it came from menstrual suppression, which had excited inflammation of the Fallopian tubes; in the fourth it followed an undefined affection of the genital organs, the result, probably, of venereal excess. In the fifth case, it succeeded a puerperal abscess, though the existence of the tubercular diathesis, and the presence of tubercle in the ovaries themselves must be taken into account. No doubt that constitutional taint, and the

* T. Gallard, *Union médicale*, 1854, ix. p. 38, et x. p. 41.

lymphatic, not to say scrofulous habit, influenced materially the chronic character of the affection ; but, at the same time, I cannot attribute the pelvi-peritonitis to the diathesis, nor even to the presence of the tubercle found after death in the ovaries ; and for the following reasons :—1st. Because it came on after an accouchement six years previously. 2nd. Because at that time the ovarian tubercles were in a very crude condition ; and 3rd. Because the pulmonary phthisis was not developed till long after the genital affection. It would seem, therefore, that the pelvi-peritonitis, and the treatment which that required was, probably, the exciting cause of the consumption to which the patient was constitutionally liable ; and that the ovarian tubercles cannot be charged with creating the serous inflammation.

But if the case does not admit of that interpretation, there are others in which the presence of tubercle in the ovary seem manifestly to have originated chronic pelvi-peritonitis, and thus to have given rise to a complex affection which, by its progress, and the lesions found after death, is precisely analogous to tubercular orchitis. The following case, taken from the work of M. Aran,* is a remarkable example of this kind of tubercular feminine orchitis ; but I regret that he has given an entirely different title to it from that which most people would have chosen.

CASE VI.—*Lumbar pains following labour ; ante- and right latero-flexion ; pelvi-peritonitis ; suppuration ; puncture per rectum, and escape of pus.—Subsequent tuberculosis ; typhoid fever ; death.—Autopsy ; tubercular disease of lungs ; abdominal peritoneum normal ; adhesions of pelvic peritoneum and tubercular granulations ; tubercles in mesenteric glands ; right ovary shrunken with cicatrices ; corresponding tube wide open at peritoneal orifice, and containing a quantity of pus and tubercular matter ; the mucous membrane infiltrated with tubercle ; left ovary containing softened tubercle ; corresponding tube filled with pus and tubercular matter.*

A woman 33 years of age was admitted under the care of M. Bernutz, June 4th, 1857, suffering from facial neuralgia. She complained of having had pains in the loins since her confinement six years before ; these had become worse the last two years. Menstruation began at 12, and had continued regular. On examination, the

* Aran, *Leçons cliniques sur les maladies de l'utérus et de ses annexes*, p. 634. Paris, 1858.

uterus was found to be ante- and latero-flexed. The fundus being in front and to the right, the cervix behind and to the left, it could easily be replaced. Granular ulceration existed round the os. The neuralgia was speedily cured with aconite, and she left the Hospital. Five months after, November 24th, she was re-admitted for general debility and loss of flesh, bearing-down pains and dysmenorrhœa ; the uterus was found depressed ; the cervix large and granular.

By rest, emollient and opiate applications, she greatly improved, and the ulceration healed, when, in December, she was seized with severe pain, first in the left, then in the right iliac fossa. Menstruation came on eight days before its time ; the pain increased ; she had rigors, fever, loss of appetite, &c.

On examination, December 7th, the uterus was still in the same position, but completely fixed ; and adjoining it was a tumour, round, tender, the size of a hen's egg, extending backward beyond the uterus. Ordered twenty leeches to the right iliac fossa ; calomel and opium ; emollient poultices, &c.

Under this treatment, twelve more leeches being applied to the cervix, she recovered. On the 12th the cervix and vaginal walls felt œdematous ; examined per rectum the tumour seemed to occupy the entire pelvis, and was very elastic. On being punctured with a trocar a cupful of pus escaped. This gave great relief, though the tumour did not seem to diminish in size.

On the 15th, another swelling, the size of a turkey's egg, was detected on the right side of the uterus ; occupying great part of the pelvis on that side, fixing the uterus, and pressing on the rectum.

On the 18th this was punctured with a trocar without result ; but a few hours after, pus passed by the rectum in large quantity, producing marked relief and diminution of the tumour—then the uterus was found to be adherent on the left side. She subsequently left the Hospital, much relieved locally ; but was re-admitted with evident tuberculosis, from which she gradually sank, and died April 4th.

On *post-mortem* examination, a good deal of serous fluid, lymph, and pus, was found in the pelvis, with some firm adhesions ; the peritoneum here was also scattered with miliary tubercles, mesenteric glands the same. The uterus was adherent to the bowel and bladder in front, and to the rectum behind ; pus, serum, and lymph were infiltrated among these parts, and tubercle in the false membranes. The right ovary was remarkably small, from cicatricial contractions. The right tube was doubled in size ; its free end wide open ; its walls

thickened; and it contained a good deal of pus and broken down tubercle, which incrustated its lining membrane. The left ovary was tubercular; the left tube in very much the same condition as the right. The uterus was tolerably healthy. The thoracic viscera were studded with tubercle.

I need not insist here upon the great similarity between this case and cases of tubercular orchitis; all the details of the one, the symptoms during life, and the appearances after death, correspond with those of the other. There is first the changes in the ovaries; the one, a shapeless mass exactly resembling a testicle destroyed by tubercle; the other, containing softening tubercle in its carnified parenchyma, represents a tuberculous testicle. Then, the pathological condition of the tubes, the mixture of pus and softened tubercular matter which they contained, and the tubercular infiltration of their mucous membrane, exactly corresponds with the alterations of the epididymus and vas deferens in tubercular orchitis. Moreover, the condition of the pelvic peritoneum, the serous collections in some places, the purulent in others, and the more or less advanced tubercular deposits of which it was the seat, present us with an almost absolute identity with the alterations of the tubercular tunica vaginalis. Lastly, the tubercularisation of the mesenteric glands, and the miliary infiltration of the lungs, complete the analogy of the two cases in the two sexes.

Nor is the analogy less complete in regard to the symptoms. The earlier symptoms in the case just detailed, correspond with those occurring in the male; the pelvi-peritonitis arising in the one from tubercularisation of the ovaries, while in the other the tubercular orchitis is the starting-point of the mischief. This form of pelvi-peritonitis presents this remarkable peculiarity, that notwithstanding its apparent benignity, it almost invariably results in suppuration; which, I may add in passing, presents the character of spurious peri-uterine phlegmons. After puncture, pus—and with it, as we have found, part of the ovary escapes, per rectum; this evacuation is followed by a temporary improvement, similar to that which follows in tubercular orchitis, where a puncture or incision of the distended tunica vaginalis allows the escape of pus and testicular debris. Then follow alternations of improvement and exacerbation, during which the constitution becomes seriously altered, and signs of pulmonary tubercularisation appear, just as obtains in tubercular orchitis. I

shall say nothing of the typhoid fever, which seemed at the last to quicken the chronic peritonitis ; because this supposition is contradicted by the following case, in which nothing of the kind occurred, though typhoid fever was therein developed almost immediately after the patient left the Hospital, where she had had symptoms of spurious peri-uterine phlegmon.

CASE VII.—*Menstrual suppression from cold, followed by abdominal pains ; admission into the Hospital seven days after, when a tumour on the left side of the uterus was discovered ; treated with benefit by the application of leeches to the cervix ; discharged cured ; re-admitted with typhoid fever, from which she died sixty-nine days after the first suppression.—Autopsy.—Ulceration of Peyer's patches ; adhesion of the right Fallopian tube to the corresponding ovary, and between all the pelvic organs.—Ante-version and slight latero-version of the uterus, which was healthy ; ovaries healthy ; right Fallopian tube contained muco-pus ; left healthy ; cellular tissue of both broad ligaments perfectly healthy.*

A young woman, aged 23 years, was admitted into *La Pitié* the 7th of March, 1857 ; was rather delicate as a child, suffering a good deal from headache. At 17, menstruation began without pain, but it has been very irregular ever since, and she has always had leucorrhœa, and been subject to dyspepsia. On the 1st of March menstruation came on as usual, but it stopped suddenly, after she had been washing some linen in cold water. The next day she felt very uncomfortable, and in the evening was seized with severe abdominal pain and tenderness. The following day the pain was so sharp, and was so much increased by movement, that she was obliged to keep in bed. Emollient and opiate applications were used, but she got no relief, and was accordingly admitted into the Hospital, when the following state of things was discovered. Great tenderness on pressure over the hypogastric and iliac regions, especially to the left of the median line: Vagina hot ; cervix small, directed to the sacrum and to the right ; no granulations ; body of the uterus directed towards the pubis. In the right cul-de-sac could be felt a tumour affixed to the right border of the uterus, sharply defined below, but ill-defined above where it was soft ; pressure in this cul-de-sac gave pain, but still more so on the left, where only a slight ill-defined swelling could be felt. Examination of the posterior cul-de-sac was rendered difficult by the ante-verted uterus, movement of which caused pain. Ordered four leeches to the cervix ; poultices to the abdomen ; rest, &c.

The leeches bled freely, and gave great relief. For the next week or two she continued to improve, but still there was pain and tenderness over the abdomen, especially on walking. The tumefaction in the left cul-de-sac disappeared; that in the right considerably diminished, and became so separate from the uterus as to seem like the ovary.

There was a slight aggravation of the symptoms with the next return of menstruation, but she left the Hospital on the 8th of April. She was re-admitted in ten days for an attack of typhoid fever, during which menstruation came on quite normally and without pain on the 21st of April; but she died on the first of May.

Post-mortem examination.—Passing over the evidences of the typhoid fever; it was found that the uterus was completely ante-verted. The cervix small, conical; the anterior surface of the uterus was quite healthy; the peritoneum and sub-peritoneal tissue were also quite healthy. Posteriorly the uterus was adherent, especially at its lowest part, both to the rectum, and, on the right, to the ovary and Fallopian tube. The uterus was slightly curved on its right lateral border. The cellular tissue posteriorly was quite healthy, as was the cavity of the cervix and body of the uterus. The left tube was healthy, as also the left ovary. The right ovary was adherent to the corresponding border of the uterus, its tissue deeply injected; on its posterior aspect was an opening which had given exit to a collection of muco-pus, amounting to about a cup-full. This fluid had been formed in a cavity, composed mostly of the Fallopian tube at its pavilion extremity; some of the same fluid was seen in the tube itself, which throughout its entire length was permeable, somewhat enlarged, and completely encircled the ovary.

The observations which I made, after my first cases, to prove the correlation which exists between the symptoms and the lesions, more particularly the signs of the peri-uterine tumours and the peritoneal lesions, render it unnecessary for me further to allude to the subject; but, apropos of the preceding case, I must give a resumé of the anatomical lesions described not only in this, but in Cases II. and III., all of which belong to the same variety of pelvi-peritonitis, viz., the menstrual, the symptomatology of which I shall discuss presently. I do not pretend to be able, from three cases, to trace completely the pathological anatomy of this important variety of feminine orchitis, but merely to give a sketch, the deficiency of which will be supplied

by the observations of others. If this sketch is not complete, it has at least the advantage of showing what lesions occurred and could be demonstrated anatomically at different periods after the commencement of the affection; death having taken place in one case (III.) on the twelfth day, in another (VII.) on the sixty-ninth day, and in the latest (II.) at the end of the third month after the menstrual disturbance which originated the pelvi-peritonitis.

I need not say that lesions of the pelvic peritoneum existed in these three cases, nor need I minutely describe those lesions, upon which I have so frequently remarked before, in order to prove that it is the inflammatory products of the serous membrane which constitute the peri-uterine tumour discovered by vaginal examination. I shall only remark that in one of these cases (III.) the pelvic peritoneum formed a true purulent cyst; that in another (VII.) there existed, in the midst of numerous adhesions, a small muco-purulent cyst between the ovary and the tube; and that in the third (II.) the serous membrane only presented some cellular bands which remained as indelible signs of the previous inflammation. I must, however, direct special attention to the integrity of the ovaries, a point which I have already alluded to in treating of blenorragic pelvi-peritonitis. These organs, in two of the cases, (II. and III.) were perfectly healthy; in the other (VII.) the parenchyma of the ovary, though very congested, was not altered; but there existed on the surface an ulceration which could not, I think, be regarded as a lesion of the ovary itself, since it only involved the peritoneum. It is right also to say that, in these three cases, the ovaries were healthy, barring the presence or absence of the physiological clots which they contained: these were not found in Case II., but were present in Case VII., where they presented the well-marked characters of ovulation, the one twenty days old, the other a month older.

As against the healthy condition of the ovaries may be placed the lesions which the Fallopian tubes presented in these three cases, and I may add the two others mentioned below,* which show plainly

* Case of Mr. Harrison, of Louisville, *Amer. Jour. of the Med. Sci.*, February, 1835, p. 372.

I was requested by Dr. Talbot to see, with him, Mrs. T., the wife of a merchant, who had been ill for two or three weeks. She had been married six months. It was on the 18th May, 1834. There was a good deal of fever, nausea and vomiting. A painful swelling was felt in the left iliac fossa.

that these canals, the analogues of the vas differens and epididymus conjoined, had been the seat of inflammation, which, as we have already seen in cases of blenorrhagic pelvi-peritonitis, is the source of the serous affection. This inflammation was revealed, in one (III.) of my three cases, by distension of the two tubes with phlegmonous pus, similar to that which was found in the peritoneum; and by the villous condition of the mucous membrane, especially of the two fimbria, which were adherent to the ovaries. In another case (VII.) it was shown by the tumefaction of the right tube, the greyish colouring of its mucous lining, the union of the ovary to the fimbria, and lastly by the distension of that sort of cavity which imperfectly suggests what has been described as a physiological condition,* by a muco-purulent collection, similar to that found in the tube.

Again, in Case II., this inflammation was revealed by direct adhesions between the tubes and ovaries, by the thickening of their walls, the grey colour and villous condition of their mucous lining; and, lastly, by the dilatation of the extra-uterine portion of both oviducts, one of which contained muco-pus, while the other was full of a peculiar red syrupy fluid, which seemed to show that this tube had been the seat of a collection of blood, then in process of absorption. To sum up, then, we may say that in these three cases there existed inflammatory lesions of the tubes, which may legitimately be regarded as the source of the peritonitis, and that this was determined in the one case by simple contiguity, in the two

Examination per rectum was painful; the os uteri was swollen and tender; for the last two months, menstruation had been very painful. The treatment consisted, in the main, of leeching and blistering. She improved somewhat; when, in time, symptoms of phthisis set in, and she died. On making a *post-mortem* examination, the principal lesions were distension of the Fallopian tubes, especially the left, and closure of their uterine orifices. The ovaries were enlarged, and all matted together and to the rectum, which was compressed by coagulable lymph. The left tube contained thirty-two grammes of pus.

Case by M. Andral, *Clinique médicale*, t. ii. p. 687.

A woman, 36 years of age, suffered sudden menstrual suppression from cold. This was followed by severe hypogastric pains, vomiting, diarrhœa. Pleuro-pneumonia set in, and she died. On *post-mortem* examination a pouch of pus, the size of an orange, was found behind the uterus. The left ovary was also enlarged, and contained pus.

* See the case of M. Panck, vol. i. note, p. 2.

others by the escape of morbid secretions from the tubes into the pelvic cavity.

With these lesions, which approximate the menstrual to the blenorrhagic form of pelvi-peritonitis, I may group together those of the uterus in the cases just analysed. I need not repeat that in these three cases, as in all those I have reported, including the interesting case of my friend, M. Boucher, where death occurred twelve days after menstrual suppression, the peri-uterine cellular tissue was perfectly healthy. Turning from the discussion of this subject, which seems to me exhausted, I pass on to consider the various uterine lesions which are less hypothetical than those of the cellular tissue, which no one has ever seen, and shall direct attention to what I actually met with in those three cases, though more are required to substantiate them. They are of two kinds; in the one, death having occurred some little time after the commencement of the pelvi-peritonitis, uterine deviations existed; and in the other, an example of which is seen in Case III., where death occurred on the twelfth day, dilatation of the uterine cavity, and an abnormal condition of its mucous lining were found.

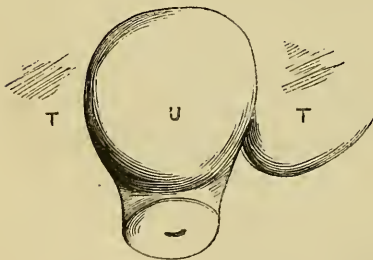
I shall not now discuss the deviations of the uterus which were met with in these two cases, because this point will be considered at length in the succeeding memoir by M. Goupil, but I must notice the abnormal condition of the uterus observed in Case III. The points to be considered are, whether the dilatation of the uterine cavity by bloody mucus, similar to that which was expelled a few days before death, and the reddish discoloration of the mucous lining, were signs of chronic metritis antecedent to this menstrual suppression; or were, on the contrary, the disease itself. I reject the former supposition; first, because it is contradicted by the patient's antecedents; secondly, because it takes no account of the presence of the altered blood found in the uterus in this case, and in the tube in another (II.); and, above all, because it ignores the sanio-sanguineous discharge observed in the three cases of menstrual pelvi-peritonitis; which seems, from its frequency in this variety of feminine orchitis, to be related to the functional disturbance which it follows: and, lastly, because the discoloration of uterine mucous membrane, so far from being regarded with certainty as a lesion, may, under the circumstances, be more legitimately regarded as a cadaveric absorption of the blood in contact with the mucous membrane. I do not deny that the uterine cavity, which presented a villous appearance,

may have been the seat of inflammation during life ; I only deny its chronic character ; for it seems to me, on the contrary, to have been of recent origin, and to be connected with the difficulty in the menstrual excretion, to which the inflammation was consecutive, not antecedent. In fine, I believe that the disturbance in the excretion led to repletion, and caused permanent dilatation of the uterine cavity at the catamenial period ; that the presence of the intra-uterine clot, resulting from the arrested menstrual discharge, was a helping cause in the development of the inflammation in the mucous membrane, and this was otherwise favoured by the obstacle to the complete solution of the normal congestion by the functional disturbance. But admitting this does not prove that the inflammation was propagated from the uterine mucous membrane along the tubar, and so became the starting-point of the pelvi-peritonitis ; at least, it is not proved as regards some of the cases. We may admit that it obtained in Case II., from the length of time which elapsed, and from the condition of the patient between the period of suppression and the commencement of peritonitis, but we cannot believe that this occurred in the other two cases. In both of them, and more particularly in Case III., the suddenness of the peritoneal attack after the suppression, and the multiplicity of the *post-mortem* appearances, suggest that in those two cases the feminine orchitis resulted either from a simultaneous inflammation of the entire utero-tubar mucous membrane, or from a kind of metastasis similar to that met with sometimes in the course of blenorragia in the male, or after the performance of catheterism. On this latter mode of production of the inflammation, I shall not now remark, because I shall return to it in the discussion of traumatic pelvi-peritonitis, especially in those cases occurring after the employment of the sound or uterine-dresser, in order to show that inflammation of the pelvic serous membrane results from a morbid reaction, similar to that which is occasioned sometimes by the presence of a sound in the urethral canal of the male. Before entering upon this question, I shall relate some fatal cases of pelvi-peritonitis following abortion, in which the serous inflammation sprang from inflammation of the Fallopian tube.

CASE VIII.—*Abortion at third month ; symptoms of sub-acute pelvi-peritonitis ; vomiting fifty-two days after, and jaundice, followed on the nineteenth day by delirium and coma, with death in three days.—Autopsy.—Uterus healthy ; uterine, ovarian, and iliac veins healthy ; signs of pelvi-peritonitis posteriorly and bilaterally ; collection of pus in a cavity formed by the pavilion of the tube and the sigmoid flexure ; pus in both Fallopian tubes ; a nodule of cellular tissue of the right Fallopian tube thickened and infiltrated with red serum, the rest healthy ; uterine cellular tissue also healthy ; liver atrophied ; pulmonary congestion.*

E. D., aged 19, admitted into the *Hôtel Dieu*, October 4th, 1859. Always enjoyed good health ; menstruation being quite regular till last July, when it stopped. Four days before admission she was seized with pain in the abdomen, and a discharge of blood by the vulva. On examination, no swelling or tenderness could be discovered in either of the iliac fossæ, but there was a rounded, hard, and painful swelling to be felt, a little on the right of the median line. The cervix uteri was depressed, enlarged, slightly open, and directed to the back and left side of the vagina. In the anterior cul-de-sac, the firm globular tumour above-mentioned could be felt at a right angle almost with the cervix. When the patient experienced pain, this tumour could be felt to undergo a sort of contraction. The body of the uterus could be felt in the right cul-de-sac, enlarged abnormally and in continuity with the swelling felt anteriorly. The posterior cul-de-sac was perfectly supple, but in the left some resistance was experienced on deep pressure. Ordered, rest, poultices, lavements, and sedatives. On the 7th of October a body was felt at the os uteri very much like placenta in structure. She was

FIG 5.



ordered to rest and to keep all that passed. This, however, was not attended to ; she stated that something like a large clot passed, which she threw away ; after this the discharge ceased, but the pains in the iliac fossæ continued. The cervix resumed its normal position, but the uterus was ante-flexed. In the

right cul-de-sac was felt an ill-defined, painful, and resisting swelling ; in the left cul-de-sac was felt a more defined swelling, the size of a

pigeon's egg, separate from the uterus by a distinct groove. Externally it was so tender to the touch that its outline could not be very clearly traced, but it was felt as high as the fundus uteri.

From the 10th of October to the 28th of November but little change occurred; she continued to suffer more or less pain at times; ten leeches were applied to the hypogastrium, and two blisters to the left iliac fossa; opium was also administered, but with little benefit; the tumours remained the same.

On the 29th of November bilious diarrhœa came on, with slight jaundice; and after some mental excitement she experienced pain in the head, nausea, and vomiting, but no rigors, and soon all passed off; but on the 17th of December she was taken with delirium and slight convulsions, which on the 19th passed into coma, and on the 20th she died.

On *post-mortem* examination, the epiploon was observed to be adherent to the right broad ligament. There was no effusion, but some slight adhesions of the sigmoid flexure on each side to the two broad ligaments near the uterus existed, leaving the posterior or retro-uterine cul-de-sac quite free in the middle line, which tallies with the absence of any resistance in that region during life. The uterus was acutely ante-flexed, its cavity dilated; the mucous lining injected as far only as the cervix, which was quite normal.

The right broad ligament was normal, except that a slight swelling existed in it close by the lower border of the Fallopian tube, which was here somewhat enlarged, and contained some thick creamy pus. The *ostium uterinum* was, however, free. - The fimbriated extremity was dilated, and contained some of the same matter; the right ovary was quite healthy. In separating the adhesions on the left side, between the sigmoid flexure and the left broad ligament, a small cavity containing pus was opened which, no doubt, formed the posterior part of the swelling felt during life in the left vaginal cul-de-sac: on separating the Fallopian tube from the sigmoid flexure, it was found that the anterior part of the base of this swelling was formed by the ovary; the upper part being formed by the dilated Fallopian tube: further, a collection of pus was found in that tube, the ostium uterinum being closed; the walls of the tube were here very thick, elsewhere they were normal; and, though the tube was pervious to the other extremity, yet the collection of pus at that end had not communicated with the other.

The cellular tissue of the broad ligament was healthy, as was that about the uterus and pelvis. Neither suppuration, nor induration,

nor injection, could be found in any of the cellular tissue. All the veins in the pelvis were healthy. The brain was deeply congested.

I need not remark upon the peculiar hepatic affection which during life was accompanied with jaundice, progressive debility, delirium and coma, and, where, after death, atrophy of the parenchyma of the liver was found; because I cannot trace any pathological relationship existing between that acute hepatic atrophy and the affection of the generative organs in the course of which it was developed. I may, however, direct special attention to what, in this case, is a very interesting point, viz., the perfect agreement of the examination during life with the *post-mortem* appearances, more particularly as regards the lesion of the tubes, the inflammation of which seems obviously to have been the origin of the pelvi-peritonitis. I may mention first the existence of peritoneal adhesions in the right and left lateral culs-de-sac corresponding with the points of resistance felt during life. Secondly, the absence of any adhesion found in the utero-rectal cul-de-sac, which also corresponded with the absence of any resistance discoverable before death; also the comparatively limited adhesions in the right lateral cul-de-sac, where examination during life discovered only a vague swelling. On the other hand, the firmness and extent of the adhesions on the left side corresponds with the well-defined tumour which could be felt during life attached to the border of the uterus, but separated from it by a characteristic groove. I need not insist further on these several points which are referred to in the analysis of previous cases, and will be found in those that follow; but I proceed to consider what was the starting-point of the peritoneal inflammation.

A careful dissection of each of the broad ligaments and their inflammatory products showed that on the left side the uterus, sigmoid flexure, and broad ligament were all united together by peritoneal adhesions, the fimbriated extremity of the tube forming, with the sigmoid flexure, the anterior wall of an abscess. The abscess was, by reason of its connections, both intra-tubar and intra-peritoneal—the latter arising probably from the escape of pus from the former, which no doubt led also to the peritonitis on the left side of the pelvis. The ovary was displaced downwards by the encysted condition of the tube which contained the pus. I may add, in reference to this position of the ovary, which was adherent to the uterus below the level of the internal os, and was similarly displaced in Cases I. and VII., that its perfectly healthy condition

in each case disproves the opinion of M. Aran, that this displacement is to be regarded as a sign of ovaritis. Not only was the left ovary healthy—but the right, which was also prolapsed, was healthy also.

On the right side of the pelvis, where during life an ill-defined tumefaction was discovered, there existed only two peritoneal adhesions interposed between an abnormal curvature of the sigmoid flexure and the inner part of the right broad ligament, which was indurated at this point. This induration was formed principally by a morbid dilatation of the tube, and by thickening of the cellular tissue which lined its internal surface and was interposed between this part of the tube and the peritoneal adhesions. The comparative importance of the pathological changes in the internal part of the tube, the indurated walls of which were distended by an encysted muco-purulent collection; the juxta-position of the changes in the tubar-mucous membrane, which was in a fungous condition; the thickened state of the fibrous structure of this canal; and, lastly, the indurated and infiltrated cellular tissue; all these favoured the inflammatory process. They prove that the inflammation was propagated by continuity from the cellular tissue lining the Fallopian tube, to the adjoining peritoneum. Thus, the inflammation of the pelvi-peritoneum on the two sides was connected with inflammation in the corresponding tubes, though its mode of propagation differed. On the left side it was produced by an intra-peritoneal effusion of morbid secretion from the tube; while on the right side the extension of the inflammation from the mucous membrane to the peritoneum and the different tissues, especially the cellular tissue, affords characteristic evidence of the morbid processes. I must not omit a reference to the small nodule of thickened cellular tissue which existed in the right broad ligament. This little body is, I believe, evidence of the fact that inflammation of the tube may be the starting-point of phlegmons of the broad ligaments; but the circumstances in this case are peculiar, inasmuch as the morbid process was limited to a very small spot, instead of involving the entire ligament. Under ordinary circumstances, it is the peritoneum which is involved in the tubar inflammation. Another point of interest is established by the discovery of this little nodule of cellular tissue so long after the abortion, and after the commencement of the genital affection, viz., that inflammatory changes in the cellular tissue of the generative organs are not so ephemeral as M. Nonat has

supposed; * that they remained for a long time; and, consequently, that in the absence of convincing evidence, we ought not to say that this cellular tissue has been the seat of inflammation, when no proof of phlegmon is discovered after death. The slight thickening, and the sero-sanguineous infiltration which existed in the preceding case, and also in a case of phlegmon of the broad ligament which I shall presently refer to in a note, disposes of the objections of M. Nonat to the conclusions advanced in my first memoir. The value of the cases I have already reported, where the peri-uterine cellular tissue was found to be perfectly normal, is thus greatly enhanced. The following is another case of the kind, in which pelvi-peritonitis followed a criminal abortion.

CASE IX.—*Abortion, followed by pelvi-peritonitis; admission into the hospital four days after, when only slight deposit was felt about the uterus; gradual formation of a swelling in the left and posterior culs-de-sac, pushing the uterus forwards and to the right; uterus easily replaced, but fixed in its normal position by adhesions to the rectum.—Death fifty days after the abortion.—Autopsy.—Adhesions between the uterus, broad ligament and rectum; dilatation of the left Fallopian tube, and distension with mucopus; right tube healthy; ovaries healthy; phlebitis of the tubo-ovarian veins, the right and left plexuses, the hypogastric and right-crural and iliac veins. Uterine cellular tissue quite healthy.*

C. M., aged 33, admitted into *La Pitié*, November 28th, 1859; married, but separated from her husband for some months. Always had good health till present illness, which began four days ago. Menstruation began normally at 18, and has continued regularly ever since. Her first labour was natural; menstruation came on six weeks after, and continued regular till her second pregnancy, which also terminated normally. Menstruation came on again at the end of six weeks, and continued regularly till the 20th September, 1859, when she separated from her husband owing to some improper intercourse which she had established. On the 20th October menstruation did not return, and she became, under the circumstances, alarmed for the existence of pregnancy. On the 20th November the same was repeated, and, she being convinced of the existence of pregnancy, determined to bring on abortion. From the 20th to the 24th she tried various means, by which she brought on a discharge, and,

* Nonat. *Loc. cit.*, p. 242, 247.

according to her statement, the ovum was expelled. From the time the loss began, she says she had abdominal and pelvic pains up to the time of her admission.

She was then in a state of great prostration, and complaining of a good deal of abdominal pain, which was increased by pressure. The vagina was very hot; the cervix soft, open, and had all the characters of recent abortion. An ill-defined puffiness existed round the cervix. The discharge was still very free. Ordered, rhatany, seltzer water, and opiates.

On the 30th she was worse; pains increased, especially in the left iliac fossa. Per vaginam, the swelling was more definable; the cervix elevated. A blister was ordered to the left iliac fossa. Some patches of aphthæ appeared on the tongue, and were touched with the ammonio-sulphate of copper. On the 4th of December the pains were much more severe; the vaginal walls in folds; the cervix pushed against pubis, and behind it a firm elastic tumour, occupying the greater part of the posterior cul-de-sac, and extending to the left, which it completely filled; it presented no irregularities. The examination caused so much pain that, notwithstanding the enfeebled condition of the patient, four leeches were ordered to be applied to the cervix, to be followed by a bath. This gave marked relief.

After a few days an erysipelatous inflammation came over the part where a blister had been applied, and the result of this was apparently very marked; for the tumour at once subsided, so that the cervix resumed its normal position, but it was fixed there by adhesions. The inflammation, however, continued of an erysipelatous character about the blister, and the patient gradually sank, and died on the 13th of January.

Post-mortem examination, thirty-six hours after death.—Before opening the abdomen a vaginal examination was made; the cervix was found very high up, in front. There was slight latero-version to the left side. Posteriorly, and to the right, all was normal; but on the left, the cul-de-sac was less deep, and an indurated mass was felt there, occupying the entire left cul-de-sac; it had a pasty non-fluctuating feel, with some irregularities on the surface. On opening the abdomen, the uterus was seen to lay horizontally on the rectum from left to right. The right broad ligament, Fallopian tube, and ovary appeared healthy. The left broad ligament was covered with false membranes which drew the left border of the uterus to the tube and ovary. The tube itself was dilated almost to the size of the

finger. The ovary was completely buried in false membrane. The bladder was normal; posteriorly, the uterus was adherent to the rectum, but there was no purulent collection, though there was a good deal of false membrane in this situation. The peritoneum was very firmly adherent to the uterus; so much so, that it was torn in pieces in attempting to remove it. The interior of the uterus was healthy. The cellular tissue was everywhere healthy. The left ovary was healthy. The left tube contained a good deal of mucopurulent matter. The larger veins in the broad ligaments were dilated, their walls thickened, and they contained some coagula. The right utero-ovarian vein was double the size of the left, its walls thickened, and its contents clotted. The hypogastric and right iliac veins were the same. The abdominal peritoneum was healthy, as were all the abdominal viscera. The lungs contained evidence of tubercular disease. The heart was normal.

I shall not analyse this case, which would only be to repeat remarks previously made, especially in Case VIII. I might have refrained from reporting it, if I had not to rebut the criticisms of Dr. West,* who charges me with having published only exceptional cases in my first volume, and with taking exceptions for the rule, and vice-versa. These remarks of the English author are quoted below (though of little value in themselves)†: they prove that Dr. West confounds very

* West, *Diseases of Women*, p. 430. 2nd edition. London, 1858.

† Case of Dr. West, (*Diseases of Women*, second edition, p. 428.)

This patient died twenty-one days after premature delivery, with placental presentation. She suffered a good deal from deep-seated pains in the back and loins, which gradually extended over the abdomen. After death, the uterus was found to be pushed up by a collection of more than eight ounces of chocolate-coloured grumous pus, which had formed in the left side and back of the organ, the upper part of the abscess reaching to about one and a-half inches above the arch of the os uteri. There was no general peritonitis; no disease of the uterus itself; both ovaries were healthy; death having taken place from inflammation and suppuration of the cellular tissue about the uterus, just as it takes place from the same affection of the tissue between the rectum and bladder after the operation of lithotomy in the male subject.

Dr. West records two other cases of a very similar character, in both of which there was evidence of inflammation and suppuration being limited to the cellular tissue about the uterus; in one it was in the left broad ligament; and in neither was there any trace of peritonitis, except in the one where some old adhesions bound the uterus and rectum together.

unreasonably, peri-uterine phlegmons with those of the iliac fossa. The latter I am not now considering, but only the former, as described by M. Nonat; of which, at the time of the publication of my first memoir, he could produce no anatomical proof; and, consequently, I was at liberty to question his theory without meriting such severe criticism. Nor is it now more deserved; since, in the three years which have elapsed since the publication of my memoir, only two cases have occurred in France in favour of M. Nonat's opinion—and these certainly will not appear very convincing to those who read them; the one being very incompletely recorded; while the other is a case of critical abscess occurring in the course of small-pox. The former was reported by M. Demarquay to the *Société de Chirurgie*, the specimen was exhibited at the sitting on the 7th of April, 1858, and will be found described in the *Gazette des Hôpitaux* for April 17th, 1858. The latter, a case by M. Simon, will be found in the *Bulletins de la Société anatomique de Paris*, xxxiii^e année, 2^e serie, t. iii. mai, juin, 1858, n^o 20, p. 234.

It must be admitted, however, that these two cases, imperfect though they be, and the only two which can be quoted in favour of M. Nonat's opinion, render it impossible for us to deny the existence of peri-uterine phlegmons; and it is equally certain that pelvi-peritonitis is not so rare an affection as Dr. West has supposed. The number of my cases, none of which are incomplete, is much greater than those which are adduced as examples of peri-uterine phlegmons; and this, I think, proves that pelvi-peritonitis is the rule; peri-uterine phlegmons, if they exist, which I do not dispute, the exception; notwithstanding that the opposite opinion is held in England. I shall not further insist upon this point—which cannot indeed be controverted, except by the production of a number of carefully recorded cases, together with their actual *post-mortem* appearances. The latter is a point of absolute necessity in all gynæcological researches; and it is especially so in the case of peri-uterine phlegmon, a disease, the anatomy of which has been simply traced out by induction.*

I shall terminate this discussion by quoting a case from the clinique of M. Andral; which, with the exception of the particulars of the vaginal examination, resembles very much the cases of chronic phlegmons reported by M. Nonat.† I quote this case chiefly for

* Nonat, *loc. cit.*, p. 247.

† Nonat, *loc. cit.*, p. 710.

the remarks made upon it by M. Andral which show that my work is, in fact, only the *mise en œuvre* of ideas which have long since been received and accepted.

CASE X.—*Pelvic pains simulating neuralgia, following labour; hectic fever; acute peritonitis—Death.—Autopsy; recent peritonitis; old intra-peritoneal collection of pus, situate between the uterus and rectum.*

A young woman, after her first labour, was subject to severe intermitting pains in the hypogastrium, behind the pubis, and radiating thence to the cervix uteri, and the lumbo-abdominal regions. About a month after admission into *La Charité*, these pains gave place to others more severe and continuous. She was treated with leeches, blisters, and emollient and opiate applications. Diarrhœa supervened, and she died.

On *post-mortem* examination, there was evidence of recent acute peritonitis; and on searching for some explanation of the old standing hypogastric pain, a tumour, the size of an orange, was discovered deep in the cavity of the pelvis, behind the uterus and in front of the rectum, but extending on the left side beyond both those organs. Its walls were formed of false membranes, and it contained purulent matter. The uterus, ovaries and rectum were healthy.

“These different varieties of partial peritonitis exist less frequently alone than as a complication of certain affections of the pelvic organs, especially of the uterus and ovaries; in a certain number of cases of chronic metritis, also, we find around the uterus one or more purulent deposits, which are evidently situated in the peritoneum.”

It is unnecessary for me to make any comment either upon these remarks of M. Andral, or on the following quotation, which he placed a little further on in his work, and which is very appropriate to this Memoir:

Multa renascentur quæ jam cecidere, cadentque.

Quæ nunc sunt in honore.....

These remarks prove that the facts which I have recorded are not exceptional, and that they were known long ago. They also prove that the physical signs of partial pelvi-peritonitis have not been

compared with the anatomical lesions; and, therefore, the fact has not been recognised that inflammatory products of the serous membrane give rise to tumours in connection with the uterus, which, to the touch, resemble cases of phlegmon. It is this which I have demonstrated in the first part of my work on spurious peri-uterine phlegmons, where I have instituted a comparison of the lesions found after death with the symptoms observed during life. The result of my dissections proved to me that I was greatly deceived in my earlier cases in attributing the tumour therein discovered to a swelling of the peri-uterine cellular tissue, and taught me to recognise that that swelling was caused by the pelvic viscera being all matted together by peritoneal adhesions. At the same time, I learned that the sensation of a tumour was more clearly defined, according as those adhesions were more numerous and intimate. I often observed that the cellular tissue surrounding the uterus was perfectly healthy, while there were numerous signs of inflammation of the pelvic peritoneum; and this compelled me to refer the symptoms observed during life to the latter affection. The analysis of these symptoms showed such a perfect identity between the symptomatology of the supposed peri-uterine phlegmons and that of partial peritonitis, that I was forced to doubt the legitimacy of the former affection.

From all these facts, I have concluded that cases of supposed peri-uterine phlegmons ought to be classed with those of partial peritonitis, from which they differ only as regards the particular seat of the peritoneal inflammation, and the morbid conditions of the intra-pelvic organs which originate the mischief. These, however, make the exact analogue of that complex affection which in the male has received the name of orchitis.

But before reviewing the circumstances connected with the development of this form of partial peritonitis, I ought to state, in order to avoid any misunderstanding, that my doubts as to the existence of peri-uterine phlegmons apply only to those phlegmons supposed to be limited to the uterine cellular tissue; that is, to that tissue which is said to exist between the uterus and its peritoneal surface. I do not at all dispute the existence of phlegmons of the broad ligament, or of the peri-rectal tissue, which are but varieties of phlegmons of the iliac fossæ. These affections are quite distinct from those I have been considering, though the former may give rise to the latter; and in that case, the diagnosis is very obscure.

Upon this latter question I must not dwell, because the two affections

are almost always consecutive; the peritoneal inflammation following upon some morbid condition of one of the internal generative organs, the uterus, Fallopian tubes or ovaries. Unfortunately, this is generally overlooked during life, from the impossibility of discovering which of the three is affected; and thus the truth is only ascertained *post mortem*. But this makes it the more necessary that we should carefully study the circumstances under which these peritoneal affections arise. Hence I shall group together in the next chapter these etiological indications; they are of more importance in practice than any of those anatomical subtleties which furnish us with no therapeutical indications.

CHAPTER II.

ETIOLOGY.

WE have seen that cases of pelvi-peritonitis occur after delivery, either at full term, or prematurely; after menstrual disturbances; in the course of blenorrhagia; after venereal excess; and after certain traumatic measures, especially after the use of the sound. No doubt there are other circumstances also as precursors, as I shall show presently, but the former have been the more frequent during the six or seven years that I have investigated this subject. Most of the cases have occurred in the *Hôpital Lourcine*, and the majority were from 15 to 25 years of age; very few being as old as 30. It is necessary to insist upon these points, as it might appear strange that the affections in question are so seldom associated with organic lesions, and so frequently with blenorrhagia. I have taken no note of the cases observed by me when in charge of *La Pitié*, because some of the women's beds there are devoted to obstetrics; but an analysis of 99 non-obstetric cases observed in that hospital, in which the morbid conditions under which pelvi-peritonitis occurred was recorded, gave the following results:—

| | |
|-----------------------|--|
| 43 were puerperal | { 35 after delivery at term. 8 after abortion. |
| 28 were blenorrhagic. | |
| 20 were menstrual. | |
| 8 were traumatic | { 3 after venereal excess. 2 after syphilitic disease of the cervix. 2 after the employment of the sound. 1 after the use of a vaginal douche, employed in a case of membranous ulceration of the cervix. |

This table shows very clearly how great is the majority of cases of puerperal pelvi-peritonitis, which alone numbers almost as many as all the rest put together, especially if we omit the last exceptional cases. I ought to mention that, in order not to multiply the

divisions, I have included under the term *puerperal pelvi-peritonitis* not only those which occur after delivery at term, but those also following abortion; of which, however, I shall treat in a separate section.

I. PUERPERAL PELVI-PERITONITIS.

THE title which I have given to this class of cases suggests at once a most important question, viz., the relation which exists between these cases of pelvi-peritonitis and puerperal fever.

It might be thought, by my including cases of abortion in this category, that I do not recognise any relation between these inflammations of the peritoneum and puerperal fever: such, however, is not the case; I certainly think that we ought, from a practical point of view at least, carefully to distinguish between the peritonitis I am describing and the purulent variety symptomatic of puerperal fever, or rather of the malignant form. There is as much difference between these two varieties of peritonitis as between simple, primary, and metastatic pleurisy. These differences justify our regarding them as nosologically distinct, but they do not authorise our treating them as separate diseases, irrespective of the puerperal state which is their common root. The importance which I attach to this, makes me regard the peritoneal inflammation as subsidiary to, or rather as a consequence of, the disturbances in the physiologicopathological travail arising out of the delivery; and which, according to the nature of the disturbing influence and the physical or moral conditions, will be either *boni moris* or *mali moris*. Notwithstanding the opposing conditions which the two varieties of peritoneal inflammation may present, they are none the less equally symptomatic expressions of one and the same disease, the puerperal fever of our ancestors, benign or malignant as the case may be.

But it is necessary, perhaps, to avoid misunderstanding, that I should more clearly explain why it is that I differ so much from the opinion of most eminent accoucheurs, who regard puerperal phlebitis, lymphangitis, &c., as so many distinct diseases; while I on the contrary regard these merely as symptomatic manifestations of one and the same disease, *la puerperalilé*, no matter how different it may appear, according as it is normal or abnormal. Just as in the case of variola, for instance, the varieties of the puerperal state result almost entirely from conditions of the organism. In the ordinary course of things, when the conditions are favourable, the

puerperalite seems more like a normal physiological process than a disease. When, on the contrary, it pursues an opposite course, and is subject to evil influences—in the first rank of which I place mental emotions, especially when of a depressing character *—then the puerperal fever loses all appearance of a function, and assumes the character of a terrible disease. Then we see phenomena which resemble rather the malignant forms of small pox, with which puerperal fever has this in common, viz., that both give rise to multiple diseases, sometimes of a gangrenous character, † scattered in different organs.

It has happened that the secondary lesions found after death in cases of puerperal fever have, at a time when morbid anatomy assumed an exaggerated importance, to the great detriment of etiological study, led to the forgetfulness of the puerperal fever from which they emanated. It is easy to understand this as occurring then. But in the present day it would be absurd to disregard the common pathological relation of the various puerperal affections. Freed from the ridiculous theory of lactation, which served as a cloke, this pathological relationship should resume its former importance, and all puerperal affections ought now to be regarded as phenomena belonging to the several forms which the physiologico-pathological travail may assume. Thus regarded, these symptomatic affections of puerperal fever no more deserve the name of separate diseases, than do the several local affections occurring in the course of small-pox or typhoid fever. All alike are symptomatic of the primary affection, and should be regarded merely as different manifestations of it.

This disseverance of the elements of disease has rapidly disappeared before the good practical sense of observers in the present day. Unfortunately, it has not been the same in regard to puerperal fever, the description of which leaves very much to be desired; indeed, so mutilated is it, that the disease itself is almost obliterated in the number of secondary affections, which, occurring in the course of it, have been erected into distinct diseases. Still, notwithstanding all the theories which have been suggested, puerperal fever is yet a

* See the tables of M. Ténon on the epidemics of puerperal fever observed in the *Hôtel Dieu* (Ténon, *Memoires sur les hôpitaux*).

† In 1859, 1860, I saw three cases of pulmonary gangrene occurring in the course of puerperal fever.

very ill-defined disease ; it cannot however be completely effaced, for, without it, we could not at the bed-side understand either the signification or importance of the various affections which occur after delivery ; and, whatever part or organ is affected, we instinctively feel that there is a something in common which suggests the idea of puerperal fever ; and that it is in vain to hope to reject “dame typhoid fever,” as Professor Piorri has ironically called it. Hence we are forced in practice to recognise the puerperal entity which M. Beau classes with the phlegmasias, but which it seems to me well deserves to maintain its ancient place in nosological tables, and to be classed with the eruptive fevers, although it is quite distinct from them. This divergence of opinion is, however, of little importance, so long as we all admit the existence of a puerperal fever. If we do, then all the phenomena of the puerperal condition arrange themselves in a natural order ; and the various affections which occur in the course of it become, as in the case of typhoid fever, so many local determinations while they modify the progress of the fever.

It will be objected, no doubt, that parturition is an accidental physiological act ; and that we cannot consequently regard as morbid the subsequent puerperal phenomena, however grave they may be, since they are but the complimentary acts of that function : that we ought to regard as physiological these puerperal phenomena, which, properly speaking, constitute the second stage, that is, the reparative stage of the puerperal function, with its twofold objects, the finishing of a transitory state, and the returning to ordinary conditions of life. Admitting this, however, we must as a consequence object to the term morbid, as applied to phenomena resulting from traumatic lesions, since the reparative process which follows is not the same as occurs under ordinary circumstances. In like manner, to be logical, we must refuse the name of disease to small-pox and similar maladies, since they are only accidental functions which nature employs to rid the system of the infecting virus. In the same way we must cease to regard as morbid the phenomena of elimination which occur in the course of eruptive fever ; since they, like the preceding, are but different acts necessary for the re-establishment of health. It appears to me, then, impossible to deny the existence of puerperal fever, for it would imply, as a consequence, that a number of diseases were but accidental functions to restore the healthy condition, and thus deprive pathology of its true signification as the physiology of the sick.

Unfortunately, in a great number of cases, the organism is unequal to the effort necessary to effect a restoration to health by the ordinary pathological processes. Hence various modifications of disease, all of which may, however, be grouped under two heads—the one benignant, the other malignant.

These two forms exist, perhaps, in the most marked degree in puerperal fever. In one of these (typhus puerpéral de Cruveilhier)* which only lately received the name of puerperal fever,† the disease assumes such serious characters, especially as regards the peritonitis, that it resembles somewhat malignant small-pox. In the benign form, on the contrary, the symptoms, though consecutive to parturition, have the character of fresh inflammation. It is to this benign form of puerperal fever, which may be inflammatory, bilious, &c, that the cases of pelvi-peritonitis I am describing belong. These, from one point of view, deserve the name of phlegmon which M. Nonat has given to them. In fact, this title serves to distinguish this form of peritonitis, *boni moris*, from that, on the contrary, *mali moris*, which occurs in the malignant variety, the characters of which are so opposite to those of phlegmonous inflammation, that they cannot be described with supposed peri-uterine phlegmons.

The pelvi-peritonitis which occurs in the benign form of puerperal fever, differs also in its origin from that which occurs in the malignant variety. Thus, while the epidemic constitution, previous mental depression, and anti-hygienic conditions, will suffice to originate the malignant form, and, without any other cause, give rise to the purulent variety, *mali moris*; in the majority of cases it will require the intervention of some external circumstance to call into action, to use an expression of Barthez, the benignant variety which previously existed only in a sort of dynamical state. From this it results that the malignant form of puerperal peritonitis is essentially produced from within; while, on the contrary, the benignant form is often accidental, the result partly of an external, cause.

Thus, in twenty cases occurring at *Lourcine*, who prior to admission had suffered from benignant puerperal pelvi-peritonitis, there were but two in which the cause of the peritonitis was not apparent. In these two cases, which were under very favourable hygienic conditions, the puerperal affection began at the end of the

* Cruveilhier, *Discussion de d'Acad. de méd.* (*Bulletin*, t. xxiii. p. 515).

† Lorain, *Thèse inaugurale*. Paris, 1855.

first week after delivery, and assumed exactly the same form of the disease as before.*

In these, as in many other cases of benignant puerperal pelvi-peritonitis observed at *La Pitié* in 1859, the characters of the peritoneal inflammation were exceedingly well marked. In the eighteen other cases, the peritonitis does not appear to have been solely and entirely a manifestation of benignant puerperal fever, but required some other determining cause, varying both in character and in the period at which it was developed. The determining cause was:

In 4 cases, difficult parturition

„ 3 „ cold

„ 9 „ too early rising after confinement

„ 1 „ fatigue

„ 1 „ venereal excess

This shows how different may be the period of the occurrence of

* I had charge of the Obstetrical wards at *La Pitié*, from the 1st January, 1858, when the epidemic broke out, which led to the discussion on Puerperal Fever at the Academy of Medicine.

| | |
|------------------------------|-------------|
| In January, I lost | 6 patients. |
| „ February „ | 7 „ |
| „ March „ | 6 „ |
| „ April „ | 5 „ |
| „ May „ | 7 „ |
| „ June „ | 3 „ |

34 deaths in 249 deliveries.

Of these 34—in 33 there was pus in some part of the genital venous system. From the end of July to the 31st of December, the wards were closed; from the 1st January to the 31st of December, 1859, there were twelve deaths in 474 deliveries. In four of these there was pus in the veins or uterine sinuses. Two died from central placental presentation; one died of gangrene of the vagina, following the employment of the forceps from narrowing of the brim; one died from some form of cerebral disease, *no post-mortem* being allowed. In two there was acute peritonitis, in one of which a purulent cyst was discovered in the peritoneum; in the other, there was pus in the left Fallopian tube, and a purulent collection in the peritoneum. One died of obstinate diarrhœa, associated with albuminuria; one had a slight attack of peritonitis—recovered, went out, relapsed, and died of purulent peritonitis. Of the remaining 454 cases, one had puerperal mania; another had puerperal convulsions without albuminuria; one suffered from hysterical convulsions from anæmia; one had ruptured perineum; twenty-six had peritonitis, eight of which followed abnormal delivery; three had phlegmons of the broad ligaments; eight had bilious attacks, which yielded to ipecacuanha; two had pleurisy; one pulmonary gangrene; five suffered from mammary abscess. In 405 the labours were natural.

the attack under different circumstances, though it more often occurs near to the time of delivery. Thus it began :

In 15 cases, within ten days of delivery.

„ 3 „ later, corresponding with the return of menstruation.

Under the first head, we find that the peritonitis set in four times on the day of delivery ; in one of the cases there were twins, in the other a protracted and difficult labour ; so that we may perhaps regard the inflammation in both these cases as of traumatic origin. In two other cases, the inflammation began some hours after the intervention of an external agency, which might be looked upon as traumatic. It resulted from cold in one case by the mere immersion of the hands in cold water ten days after delivery ; in another from a long walk in the snow, also ten days after delivery. But cold was not the only cause which arrested the lochia in these cases, and so occasioned peritonitis ; in part, no doubt, it was caused by the patient's having got up too soon, for assuredly rest in bed is absolutely essential to recovery after childbirth.

In fact, the non-observance of this rule is the undoubted origin of many cases of benignant puerperal peritonitis observed in the *Hôpital Lourcine*. This frequency is attested, not only by twenty cases which serve as the ground-work of this part of my work, but also by many other cases which I have not been able to utilise, because they have not appeared to contain sufficiently circumstantial details. In nine cases of the former class, the peritonitis appeared shortly after the imprudent action of the patient ; in three it occurred on the day of delivery ; in one each on the third, fourth, fifth, and sixth days ; and in two on the tenth day after delivery. Some were guilty of the still greater imprudence of returning to their work almost immediately on their getting up, and were checked only by the occurrence of a rigor and some abdominal pain. But, deducting these cases, there is a point in the others of equal importance ; viz., that the rigor, the pain, and the suppression of the lochia appeared almost immediately in those cases where the imprudence was committed the day after the delivery ; while the symptoms, whether preceded or not by the more or less complete suppression of the lochia, came on more tardily (forty-eight hours in one case) in those who had remained longer in bed. I may remark, in passing, that the length of time necessary to remain in bed after delivery cannot be judged beforehand ; there is no fixed rule ; for, contrary to the popular belief in nine days, two of my cases had peritonitis from getting up on the tenth day.

The accession of benign puerperal fever may, as I have before said, happen at a time even more remote from the accouchement than I have mentioned. In three of my cases it came on more than a month afterwards; in one case from cold; in another from excessive fatigue; and in another, from venereal excess, which may always give rise to orchitis in the female, as we shall see hereafter. In some cases it is impossible to fix, even approximatively, the period of the peritoneal attack, either because of the ignorance of the patient, or because of the insidious character of the attack; the same thing happens in some forms of latent pleurisy. In the chronic form, it is often impossible to determine the commencement of the attack, until the patients' sufferings become such as to prevent their following their usual avocations.

Lastly, there is another class of cases which are of a complex character; either the patients during pregnancy had a suspicious discharge, or they had had previous attacks of pelvi-peritonitis, in which case the symptoms might be regarded either as a recrudescence of a chronic malady, or as a repetition of an acute attack excited by parturition.

II. PELVI-PERITONITIS FROM ABORTION.

The difficulties to which I have already alluded are even increased in the class of cases which I have now to consider. The inflammation may here arise from the abortive labour, or from the morbid condition which has given rise to the abortion; or the difficulty may arise either from interested ignorance or intentional deception on the part of the patient as to the first appearance of the symptoms. In the eight cases which I have observed at *Lourcine*, there were three in which it was difficult to determine whether abortion or an affection of the generative organs was the cause of the pelvi-peritonitis, because in them the existing malady, blenorrhagia, procidentia, and venereal excess, respectively provoked the abortion, and might in the non-pregnant state have induced peritonitis. One is therefore undecided whether to call these cases of puerperal peritonitis; or whether to class them as cases of blenorrhagic or traumatic peritonitis, in which the abortion was an accidental phenomenon. It is to be remarked, in reference to the last case, that the peritonitis was not developed immediately after the abortion; but a return to venereal excesses, which was no doubt the cause of the abortion, and had been checked during its progress, acted again as a determining cause in lighting up peritonitis.

In three of the eight cases, the abortion, and the peritonitis which followed, came on without apparent cause, so that there are but two out of eight, or three, if we reckon the case of venereal excess, in which any definite cause could be discovered for the peritonitis, and in each of these the cause was different. In one, the patient got up the day after the abortion, the lochia ceased, and the peritonitis set in, which continued even after the lochia were re-established. In the other, the peritonitis came on twenty-five days after the abortion, five days after an examination with the speculum, and three days after the accession of uterine pains, due no doubt to the generative affection, which was the starting-point of the inflammation. This case is so interesting that I think it well to report it.

CASE XI.—*Pregnancy; chancre exedens; abortion at the fifth month; pelvi-peritonitis on the twenty-fifth day. Recovery.*

A young woman 19 years of age was admitted into *Lourcine* on the 20th of February, 1856. Had always enjoyed good health. Menstruation began at 14, and continued regular up to the time of her having sexual intercourse four months ago, when it ceased. After this she had a yellow discharge, great scalding in passing water, local heat and irritation, pain in walking, and at last a swelling in the left groin. Three weeks before admission she detected a chancre at the lower part of the vulva, which soon spread towards the anus, causing great pain in defæcation and in sitting. For this she was admitted. The breasts gave evidence of pregnancy existing. There was a painful, enlarged gland in the left groin; two large condylomata at the anus, presenting a chancrous ulceration, which was very painful. A large chancre existed at the fourchette. The cervix was soft, enlarged; the os triangular in shape, and patulous, by reason of a large fungoid ulceration which extended up into the cervix, giving to that canal a conical shape, as seen through the speculum. She was treated with the iodide of mercury, and rest—afterwards with the local application of Vienna paste.

By the 3rd of March the sores began to improve in appearance; and by the 23rd, not only were all the external chancres cured, but the internal ulceration began to be covered with epithelium.

On the 1st of April, without any apparent cause, she was taken with a sudden hæmorrhage, accompanied by expulsive pains, and followed in a short time by the expulsion of a foetus at the fifth month; after which, for a time, all went well.

The mercurial treatment was then resumed; and, on the 25th, contrary to orders, the patient insisted on getting up and going about, when she was seized with severe abdominal pain. On examination per vaginam, the roof of that canal was found to be very hot, the uterus large, and inclined to the right side. Fifteen leeches were applied to the hypogastrium, followed by opiate poultices, and the iodide of mercury internally. This relieved her, when she again, against orders, got up on the 27th. She was then seized with rigors, fever, and abdominal pain; the vagina became hot, the uterus enlarged, and a tumour could be felt on the left border of the uterus, near the left broad ligament, about the size of a large nut. Leeches were again resorted to, rest, and poultices.

The tumour increased in size for a time, but the pains diminished; her general health improved; and she left the Hospital on the 12th of June, when the uterus was found to be enlarged, and merged as it were into the swelling felt in the left cul-de-sac, while its right border was distinct from the induration felt in the right cul-de-sac.

I shall make no remark upon this case; because it will be necessary, when I consider the symptomatology of this affection, to discuss what are the signs which belong to peritonitis and what should be attributed to the genital affection—the starting-point both of the abortion and of the peritoneal inflammation. To determine what is due to the *puerperalité*, we must make out whether pelvi-peritonitis is more frequent after abortion than after natural labour, or *vice versâ*. But, to determine this question, we require to know what is the relative proportion of abortions to natural labours, a question which unfortunately cannot be settled. We further require to know the relative proportion of cases of pelvi-peritonitis (1) to abortions and (2) to natural labours. In the absence of these statistics, I must fall back upon the experience I have gained in *La Pitié*. Judging from this, I should say that pelvi-peritonitis is much more frequent after abortion, than after labours at term.

This is what I have seen, but I should not presume to say that this is the general rule, because my experience does not extend to a sufficient number of cases; moreover, we ought to make a deduction for cases of abortion brought on criminally, in some of which the pelvi-peritonitis is traumatic. But none of these questions have I been able definitely to determine.

III.—MENSTRUAL PELVI-PERITONITIS.

IN the summary above given, which serves as the basis of my memoir, it will be seen that after puerperal pelvi-peritonitis comes the blenorragic form—at least these were the more frequent among the cases observed at *Lourcine*. Still, I do not intend to consider these now; because it will be better, I think, to consider the puerperal with the menstrual variety, (of which Cases II. III. and VII. are examples), and to compare the cases of pelvi-peritonitis arising from the disturbances of these two functions, seeing that they present so many points of resemblance, as I have pointed out elsewhere.* One point which is especially remarkable is, that menstrual peritonitis always requires some determining cause, and these very much resemble those occurring in the case of the puerperal variety.

Thus the results of the twenty cases of menstrual peritonitis which I have observed, show that the inflammation occurred three times after incomplete menstruation, from no apparent cause; twice after severe dysmenorrhœic pains; and fifteen times after sudden suppression of the menses: of these it occurred nine times after a cold; three times after severe mental emotion; once after examination with the speculum; once after cauterisation of the cervix; and once after frequent sexual intercourse during menstruation.

In the three first cases, the peritonitis came on from some difficulty in the menstrual secretion, the nature of which could not be discovered—though from the attendant circumstances it was regarded as symptomatic. In fact, in two of the cases, one of which is already reported (Case II.), the patient was suffering from constitutional syphilis, which was being treated by mercury. This seemed to check the discharge, and to shorten its duration, and soon afterwards the peritonitis set in. In very many respects this resembled that which occurs in the course of an ordinary accouchement, where it arises without apparent cause. This analogy is sometimes so very striking, and the resemblance so complete, that M. Tarnier has ventured upon the, as I think, very hazardous opinion that puerperal fever may occur in the course of menstruation. But I need not now discuss this opinion, which is at any rate novel; it may be sufficient to remark that

* G. Bernutz, *Mémoire sur les accidents produits par la rétention du flux menstruel*. (*Arch. gén. de méd.* juin 1848.)

even if these two functions, the puerperal and the menstrual, do not present so close an analogy as I have been led to expect, they are at any rate sufficiently similar to allow of our regarding the affection of the pelvic serous membrane as the reaction of the general system upon it; which, in the one case, produces a disturbance of the menstrual function, in the other that of the puerperal.

In the third case of this category, I have seen the catamenial secretion scanty for two periods, absent in the third, and followed at once by peritonitis, closely resembling that which occurs in the benignant form of the puerperal peritonitis; being characterised first by the slight reaction which it exhibits in the earlier stage of the affection, and secondly by the marked aggravation of each of the symptoms. Nevertheless, between the puerperal pelvi-peritonitis and that I am now considering, there is one well-marked distinction; it is that the progress of the former increases in severity, while in the latter it is intermitting, being provoked each time by the return of menstruation.

CASE XII.—*Constitutional syphilis; roseola; amaurosis; vaginitis; scanty menstruation, followed by complete suppression; pelvi-peritonitis of the right side, then of the left; normal menstruation; cure.*

A young woman, 19 years of age, was admitted into *Lourcine*, Nov. 14th, 1854. Menstruation began at 15, and has continued regularly ever since; but she has been subject to leucorrhœa, and to pains about the loins, hypochondriac and pelvic regions. Four months ago she had sexual intercourse for the first time, and her illness dates from that. She took some medicine, and continued her sexual indulgences, though it gave her great pain; and she had a free leucorrhœal discharge, which in the last month has greatly increased, and been accompanied with difficult micturition. A fortnight after, she discovered a chancre; and at the same time she had a nervous feverish attack. Three days ago she got symptoms of jaundice.

On admission there was enlargement of the inguinal glands, some small vegetations at the vaginal orifice, and a free, thick, yellow discharge from within; the cervix was normal, except for a small erosion on the anterior lip, the uterus slightly anteflexed. Under the influence of mercurials, the jaundice disappeared. Menstruation

came on normally. Salivation began on the 8th of Dec^r. ; and, notwithstanding treatment, it continued amending very slowly. Early in January, the sight became dim, the pupils contracted, and again mercury was resorted to, in the form of proto-iodide. Blisters were also applied behind the ears. All the syphilitic symptoms gradually dispersed. Menstruation came on regularly, but in February the old pains were rather more severe, still no tumour or swelling could anywhere be discovered per vaginam, nor any change in the position of the uterus.

On the 17th of March menstruation did not come on, the abdominal pains became more severe, but the only discoverable change was that pressure in the right cul-de-sac caused pain, and it was also somewhat less deep ; an indistinct swelling could also be felt there. The cervical follicles looked inflamed, the lumbar and iliac pains increased, and were accompanied by uterine colic, sometimes severe. Six leeches were applied to the upper and inner part of the thighs.

On the 22nd the patient was better, but the pains were still severe in the right iliac fossa and near the mesial line ; they were increased by pressure, and by any movement of the uterus, the cervix and body of which were pushed to the left cul-de-sac, which was free from any enlargement or deposit. Six more leeches were ordered to the thighs, and were again followed by relief, the period coming on without any increase of pain.

On the 9th of April the pains increased, there was a great feeling of weight about the anus, and now there was some pain on pressure in the left cul-de-sac, together with some swelling, similar to that in the right. The uterus also felt enlarged and somewhat retroverted.

By the 20th of May the period came on again normally ; and after it there seemed an evident improvement in the local symptoms. The uterus now became anteflexed, and any movement of it was still very painful. The syphilitic symptoms subsided, and in general health the patient improved.

In the course of another week febrile symptoms came on ; and on examination the tumour in the right cul-de-sac was enlarged, hot, and painful. Fifteen leeches were accordingly applied to the right iliac fossa, and laudanum poultices. This gave some relief, and in the course of the next month the improvement continued. The pains, swelling, and tenderness gradually subsided. The uterus still continued out of its normal position, with slight ante- and latero-

flexion. Meanwhile her general condition so much improved that she applied for and received her discharge.

In the two cases which followed my summary, peritonitis succeeded menstrual disturbance, though of quite another kind, inasmuch as it was due to a difficulty in the excretion of the menstrual product. It came on after attacks of dysmenorrhœa, which had existed in one case two months, in the other three; the violent expulsive pains by which they were accompanied being followed by the peritonitis. Up to a certain point, the comparison is quite justifiable between dysmenorrhœic pelvi-peritonitis, and that form of puerperal peritonitis which results from difficult labour.

The last-mentioned fifteen cases of menstrual peritonitis were also due to a difficulty in the catamenial excretion; but there is a well-marked difference between them and the cases just described, the discharge being in the one class of cases instantaneously arrested at the time of its full activity, and the peritonitis resulting therefrom: while the symptoms of the latter occur sometimes within a few hours, at others within a few days of the menstrual suppression; and, though the serous inflammation may have extended either from the uterus, tubes, or ovary, in the three cases which I was enabled to examine *post-mortem* (Cases II., III., VII.) it evidently arose from inflammation of the tubes. Still I could not, from these three cases, lay down any rule upon the subject.

We may, I think, fairly compare these cases of orchitis produced by sudden menstrual suppression, with those cases of peritonitis resulting from suppression of the lochia after labour. Thus, in nine cases, which is more frequently than in the puerperal state, the menstrual pelvi-peritonitis resulted from cold; in three it was caused by immersing the hands in cold water, in two from exposure to wet, in one from eating several ices, and in three from the patient's foolishly washing the external genitalia in cold water. These cases are so dangerous, and withal so common, that I may be excused for quoting one of them as a sample.

CASE XIII.—*Gastralgia; sudden suppression of the menses from washing the genitalia with cold water; pelvi-peritonitis; cure. Four months after, diminution of the menstrual secretion from the same cause; pelvi-peritonitis of the right side; recovery. The following month, a repetition of the phenomena; cure.*

A prostitute, aged 23 years, was admitted into *La Pitié* 20th of March, 1857. Had not enjoyed good health. Menstruation came on easily at 16, then was absent for a year; and afterwards came on regularly, but always with some lumbar pains and pruriginous irritation. After some mental anxiety, she became very hysterical, and suffered a good deal from pains in the epigastrium, neuralgias, &c. In July, 1856, she became a prostitute. In the December following, she, while menstruation was at its height, washed in cold water; this at once checked the discharge, and was followed by acute pain in the lower part of the body. For this she was admitted into the *Hôpital d'Orleans*, where under the influence of sedative treatment she improved. The pains, however, returned at the next menstrual period, and were relieved by leeches. After this, she recovered and left the hospital, when she resumed her former habit of life. In the following March, in order to conceal her menstruation, she practised frequent cold water ablutions; this was followed by sharp iliac pains, especially in the right iliac fossa; notwithstanding which, she had intercourse three times on the 14th, and twice on the 15th, all of which were extremely painful. As the pain continued increasingly, she sought admission into *La Pitié* on the 20th, when the following was her condition.

There was but little febrile disturbance, but a good deal of tenderness over the hypogastric and iliac regions; the pain being increased by any movement. The cervix was small, conical, directed posteriorly and to the left; the body of the uterus larger and anteflexed; the left and posterior cul-de-sac normal; the right was occupied by a swelling connected with the right border of the uterus, tender and hot. Four leeches were ordered to the cervix, a bath, and laudanum poultices. The leeches were repeated on the 25th, and were followed by some improvement; but on the 29th she had a chill, followed by fever and symptoms of inflammation, with increased pain and weight in the left iliac fossa and hypogastrium.

On the 1st of April, after a good deal of uterine colic, a sanguineous discharge came on; which was increased on the 2nd, and gave much relief.

On the 7th, the cervix was low down and somewhat enlarged; in the right cul-de-sac the swelling existed much as before; in the left cul-de-sac a much larger swelling existed than in the right. It was very painful now, pulsatile, soft, and easily defined; both tumours seemed to come from the uterus, on a level with the internal os, but

were distinct from it and from each other. The recto-uterine cul-de-sac was perfectly free. She continued to improve, up to the 16th, when scarcely any trace of the tumours was discoverable.

On the 21st, without apparent cause, she had renewal of pain and rigors, but without any additional local symptoms. A blister was applied to the right iliac fossa with evident relief; on the 27th she left the hospital comparatively well, and was not heard of afterwards.

Lastly, menstrual suppression was in three cases brought about by mental emotion—in one from violent passion, in two from fright, one of which was, oddly enough, caused by the dread of an examination with the speculum. It is evident that an examination of this kind, and at the particular time in question, is attended with some danger. Equally clear is it that all local treatment during menstruation is dangerous; one such case is referred to in my summary, where the mischief resulted from the application of caustic at the commencement of menstruation. Practice of this kind is especially to be deprecated in the hands of quacks, who constantly resort to it; the case above-mentioned was one of these.

The only remaining cause of pelvi-peritonitis from menstrual suppression which I have now to mention, is that of excessive sexual intercourse. This, too, like the last, has been referred to a kind of traumatism, in accordance with the generally received opinion, though I do not share in it; for it seems to me that the excessive physiological excitement of the generative organs, and especially of the ovaries, is far more important in the genesis of these affections than an insignificant traumatism.

I have not met with any case in which the non-observance of rest in bed, which is so frequently a cause of pelvi-peritonitis in the puerperal state, has produced this result. This difference is but natural; for, though the menstrual and puerperal conditions are very similar in some respects, yet are they so dissimilar in others that, while rest in bed is indispensable in the one case, it is only exceptionally necessary in the other; as, for instance, in some cases of dysmenorrhœa. Hence it is to be inferred that in such cases, during menstruation, rest of the generative organs ought to be observed, as well as during the puerperal state.

IV.—BLENORRHAGIC PELVI-PERITONITIS.

I have, in several paragraphs, spoken incidentally of the frequent occurrence of pelvi-peritonitis in cases of blenorragia. I must now return to this question, and consider it at some length, inasmuch as it constitutes a very interesting peculiarity in the history of blenorragia in the female. To do this, I must refer to the statistics previously quoted, in order to show the frequency of this affection. It appears, then, that in ninety-nine cases of pelvi-peritonitis, twenty-eight, that is more than one-fourth, occurred during blenorragia. So large a proportion is, of course, due to the special character of the Hospital where the cases were seen, and so far it detracts from the value of these figures; still they possess a certain signification. They appear to me, not only to exclude the idea of mere coincidence between the pelvic inflammation and the blenorragia, but they prove that a close relationship exists between these two diseases. It is unnecessary for me to insist on this point, which has already been elsewhere discussed;* the proportion of twenty-eight to ninety-nine seems to me to speak for itself. It negatives the opinion of Hunter as to the absolute impossibility of the existence in the female of an affection analagous to orchitis in the male; it shows, on the contrary, that this affection is very common; much more so, indeed, than might be gathered from Ricord's description of blenorragic ovaritis.

To appreciate the true value of these figures, it is necessary to compare them with the total number of cases admitted. During my attendance in the sixteen months which I devoted to the study of this question at *l'hôpital Lourcine*, ninety-three patients were admitted with blenorragia, of which twenty-eight were affected with pelvi-peritonitis. It is evident then that this latter affection is very common—so much so, indeed, that I think I ought to point out some of the circumstances which might have increased it. Foremost among these, I would place the social condition of the patients admitted into *Lourcine*, which, in cases of blenorragia, predisposes to pelvi-peritonitis. I ought, secondly, to point out the saddening influence of the Hospital, where the patients came unwillingly, and only from dire necessity. Lastly, I should mention that, in certain months of the year, by diminution in the number of beds, we were

* G. Bernutz et Goupil; *Archives générales de médecine*, mars 1857.

obliged to admit only such as presented the symptoms of peri-uterine phlegmons.

I have dwelt on these circumstances, not for the purpose of drawing the conclusion, which would, in my opinion, be entirely erroneous, viz., that the inflammation of the pelvic serous membrane occurs in about one-third of the women affected with blenorragia; the only conclusion, indeed, which seems to be legitimate is, that the frequency of blenorragic pelvi-peritonitis is about the same at *Lourcine* as blenorragic orchitis is at *l'hôpital Midi*; not only do we find that the relative frequency of blenorragic orchitis and pelvi-peritonitis is about the same, but also that the period at which these two affections occur in the course of blenorragia, the genesis of each, and even their determining causes, are the same, as we shall presently see. But first let us see, at what period of the disease pelvi-peritonitis occurs; and for this purpose we must examine the fifteen cases which are explicit as to the first appearance of the purulent discharge. It appears, then, that the serous inflammation occurs at very variable periods; thus:—

It appeared in 1 case from the 8th to the 10th day after;

Once on the 12th day;

Three times on the 14th or 15th day;

Once at the end of 3 weeks;

Seven times at the end of the month;

Once at the end of 6 weeks;

Once at the end of 2 months.

Here it is seen that pelvi-peritonitis never occurred before the eighth day; that it was rare before the fourteenth; that it became frequent at the end of a month, corresponding to a menstruation; that it again became exceptional after this period, and was related to the return of menstruation. The slow development of the pelvi-peritonitis in regard to the purulent discharge, as evidenced in the previous table, agrees very remarkably with the progressive increase of the blenorragic inflammation. In no case have I seen that this pelvi-peritonitis deserves the name of metastasis; it has always seemed to me to be the result of propagation by contiguity: the inflammation extending from the vagina to the mucous membrane of the cervix, thence to the uterus, and thence to the Fallopian tubes, which thus become the starting-point of the serous inflammation. This combination, which appears to me proved by Case I., is equally evident in the following, which is interesting in several particulars.

CASE XIV.—*Urethral and vaginal blenorrhagia following sexual intercourse; hypogastric pains and globular enlargement of the uterus, with enlargement of the left broad ligament; pelvi-peritonitis in the right iliac fossa; recovery, followed by dysmenorrhœa.*

A young girl, 16 years of age, was admitted into *Lourcine*, April 22nd, 1856. She first menstruated in Dec., 1855, but the period did not return till the 12th of April, and was followed then by acute blenorrhagia, for which she sought admission into the Hospital. A month before, she had sexual intercourse for the first time; and this was followed by a good deal of sanguineous discharge. Fifteen days after, this was repeated; and then was followed in three days by a yellow discharge. On examination, the vagina was highly injected, and contained a good deal of muco-purulent matter; the cervix was small, of a deep red colour; the uterus also appeared small; the culs-de-sac were normal. Ordered cubebs, alum and nitrate of silver injections. During the next fortnight the discharge and other local symptoms improved.

On the 10th of May a small body, the size of an almond, was felt in the left cul-de-sac, at the junction of the body with the cervix-uteri. It was distinct from the latter, and very tender on pressure. She was treated for this with opiate poultices; notwithstanding which, the pains increased, especially in the right iliac fossa; and she was obliged to take to her bed. Pressure over this region became insupportable, she was feverish, thirsty, &c. Six leeches were ordered to the inner and upper part of the thigh; this gave great relief, but there still continued great tenderness on pressure; the cervix was found to be lower and more posteriorly than before; it was also slightly rotated to the right. There was some resistance in the right cul-de-sac, which was extremely painful; the left cul-de-sac was also painful, though much less so than the right. She was ordered turpentine stupes and laudanum poultices.

On the 30th she was so much better that she wished to leave the Hospital, which she did on the 31st.

A few days afterwards, having walked a good deal, she had a return of the pain, similar to, but more severe than that she had before. On the 10th menstruation came on, the discharge being offensive, but not very abundant. She continued regular till September; the periods being always painful, and accompanied by

violent uterine colic. After that time menstruation came on fortnightly.

On the 9th of November she contracted a chancre of the fourchette, accompanied by enlargement of the inguinal glands. On examination, the vagina appeared healthy; the cervix was still small; ulcerated bands were felt in the right cul-de-sac; and, in the left, a round body smaller than the uterus was made out; it was hard, and was lost in the corresponding broad ligament.

Up to the 4th December, all went on well, but she was then seized with pains resembling those of labour. A good deal of clear, colourless, viscid mucus came away, and was followed by marked diminution of pain; this improvement continuing, she was discharged from the Hospital on the 15th.

I must only make a few remarks upon this case, just to summarise its leading features, without alluding to those which have no special reference to my subject. The point of interest to us is the existence of uterine blenorragia, supervening at a menstrual period, and attended by the following symptoms: the purulent character of the uterine mucus, the dull aching pain in the lower part of the hypogastrium, and the increased volume of the uterus, also the enlargement of the left broad ligament, which pushed the uterus to the right, the lancinating pains on pressure, which seemed to indicate that the blenorragic inflammation had spread from the uterus to the tubes, and perhaps even to the left ovary, before involving the peritoneum—just as pain and swelling of the vas deferens and epididymus precede the development of orchitis—within six days of the occurrence of these symptoms, and after increased lumbar and hypogastric pain, inflammation of the pelvic peritoneum set in on the right, not on the left side—indicating by this change of situation the variety of orchitis which M. Ricord has called *orchite à vascule*. There is one very important point to be noticed, as it supervened immediately on the peritonitis, viz., the almost complete suppression of the morbid secretion from the vagina, the purulent discharge from the uterus remaining.

The character of these facts and the order of their occurrence, seem to prove that the peritoneal inflammation was not metastatic, but was the result of the gradual extension of the blenorragia, which was propagated successively from the superficial to the deeper parts. Improved by treatment, and especially by rest, this inflammation

again broke out after some fatigue, though it may also have been influenced by coming near a menstrual period, which in fact came on a few days after, and was followed by decided relief ; after which, not only was sexual intercourse innocuous to the patient, but it was not even infectious.

It is doubtful whether the dysmenorrhœa which existed in this case was due to the flexion of the uterus, or to the morbid condition of the cervico-uterine mucous membrane. I shall not stay to argue this point—this is not the place to do so ; but I believe that the inflamed condition of the cervical membrane was really a cause of obstruction, just as happens with the urinary secretion in the case of cystitis. With regard to the frequent attacks of metrorrhagia, I do not allude to them now, because I shall have to study this question in the symptomatology of supposed peri-uterine phlegmons. But I cannot conclude these observations, without recalling more particularly the dates when the peritonitis began, and when it was subsequently aggravated, both being at the menstrual period. I mention this fact chiefly because, as we shall see hereafter, menstruation is one of the most frequent exciting causes of peritoneal inflammation in cases of blenorhagia.

Unfortunately, it is not possible to determine statistically the relative frequency of these several determining causes. My observations are in this respect very complex, there being five only in which the pelvi-peritonitis was clearly traceable to one specific cause. In four of these, the inflammation came on slowly—four, six, eight weeks after the commencement of the discharge ; and, apparently, was excited by the menstrual function. In the fifth, as I have several times stated, it seemed to come on from fatigue. In the other cases I have found united all, or the greater number, of the causes to which I have referred ; viz., fatigue, deficient treatment of the blenorhagia, venereal excess, or at least sexual intercourse up to the time of admission into the hospital, when most frequently the peritonitis had begun. To these causes, both in the male and female, I attach great importance in the history of blenorhagia, and the extension of the mischief from the more superficial to the deeper parts. In like manner, venereal excitement, especially when immoderate—and that unfortunately is not rare, is a most fertile source of pelvic inflammation. I have good grounds for believing that, during the acute stage of blenorhagia, sexual intercourse is very prejudicial ; this is abundantly proved by the practice at the *Hôpital Lourcine*.

But even where there is no blenorragia, venereal excess is frequently followed by inflammation of the pelvic serous membrane. This question I shall now consider in the following section.

V.—TRAUMATIC PELVI-PERITONITIS.

Before entering on this subject, I would remark that I do not attach the slightest importance to the title which I have given to this section; for, indeed, it is legitimately applicable only to the last varieties comprised in it. It will be necessary to consider this under three heads: First, pelvi-peritonitis from venereal excess; Secondly, pelvi-peritonitis from ulcerations of the cervix; and, Thirdly, the only really traumatic form, that resulting from surgical interference; of which I have already given one example (Case XXIII., vol. I).

The cases comprising this group number eight only of the ninety-nine; and, of these, three only deserve the name traumatic; as may be seen in the following table, which shows that:

Three times, pelvi-peritonitis followed venereal excess.

Twice, it occurred in the course of uterine chancres.

Once, it came immediately after using a vaginal douche, in a case of membranous ulceration of the cervix.

Twice, it came immediately after the employment of the hydrometer.

The difference between these several determining causes is so great, that it will be necessary at least to describe one case of each variety; and I shall begin with those which are the more common, and which are placed at the head of the table above.

CASE XV.—*Venereal excess; pelvi-peritonitis fifteen days after menstruation; great relief following the next period; existence of a tumour for several months, posterior to, and on the right of, the uterus. Gradual recovery.*

L. P., aged 19, was admitted into *Lourcine*, Jan. 1st, 1856. Always enjoyed good health, though she was said to be scrofulous. At 17, menstruation came on normally, but stopped again for three months; and, after a second attempt, was again arrested for three months. After this all was regular again. Five or six months ago she was servant in an hotel, and while there had sexual intercourse three or four times every night. Soon she had severe pains in both iliac fossæ, with difficult micturition, &c. For this she was treated by some one, who said it was due to prolapsus uteri; and

ordered her rest, absence from intercourse, baths, and laudanum poultices. This was continued for a fortnight, after which the period came on very freely, and gave her some relief.

On the 3rd of January, there was no sign of secondary syphilitic eruption; but an indurated ganglion existed in the left groin, and some chancrous ulcerations within the vulva. In the right cul-de-sac was a rather large swelling in the situation represented in this sketch (Fig. 6 c.). It was separated from the cervix, but apparently united to the bony wall. The uterus itself was not tender to the touch, but the tumour was; the cervix was small and latero-flexed. She was ordered sarsaparilla and iodide of mercury.

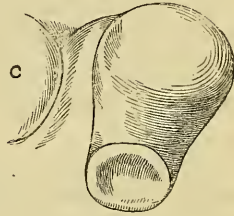
By the 1st of February the chancres were healed, and she was so much improved that she left the Hospital.

On the 17th of April she was re-admitted for syphilis; a suppurating bubo existed, her hair was falling off, and she was generally in a rather bad condition. She remained in the Hospital till the 2nd of June. The tumour gradually diminished, her health improved, and she went out fairly well.

I regret that this case, which was taken without any reference to the subject under consideration, does not contain more circumstantial details as to the modifications which the tumour (which was connected with inflammation of the peritoneum) underwent in its gradual diminution. I have chosen it notwithstanding in preference to any other, not only because of the minute information given by the patient, but also because, by a process of exclusion, the symptoms may justly be attributed to venereal excess.

1st. The absence of any bleeding at the commencement of the symptoms; the absence of a clot in the menstrual discharge, which preceded an amelioration of the symptoms, negatives the idea of puerperal peritonitis. 2nd. The period at which this pelvi-peritonitis began, viz., fifteen days after a regular menstrual period, negatives the idea of its resulting from a disturbance of the catamenial function. 3rd. The absence of any discharge before the symptoms began, its scarcity after they began, and its innocuity almost as soon

FIG. 6.



as the acute symptoms subsided, precludes the supposition that this pelvi-peritonitis was blenorrhagic. Lastly, the tardy appearance of the chancres, which appeared more than a month afterwards, and which seem evidently to have been communicated by a previous syphilitic infection, is proof against the existence of a uterine chancre as a determining cause of the pelvi-peritonitis. It appears then, according to the statement of the patient, that the pelvi-peritonitis was, in this case, caused by venereal excess, and cannot be attributed to the existence of chancres on the cervix, as existed in the following case.

CASE XVI.—*Chancres of the vulva ; and diphtheritic chancres of the cervix ; pelvi-peritonitis treated by leeching ; anæmia ; neuralgic pains ; gradual recovery from the pelvi-peritonitis.*

V. R., æt. 17, was admitted into *Lourcine*, December 4th, 1855. Always enjoyed good health till she was 15 years old, since when she has been delicate, and subject to pelvic and lumbar pains. In June last, these pains became a good deal aggravated, and for the first time menstruation came on, and lasted four days. This was in like manner repeated in August, but has not returned. Both before and since menstruation she has frequently had sexual intercourse, but has not had any discharge or sores until the middle of last September, when she contracted a discharge which was treated with alum injections. Early in November she first noticed some sores on the vulva ; and, soon, round the anus also. This was accompanied by some feverishness, loss of appetite, thirst, pains in the pelvis, &c.

On admission, the tonsils looked suspicious of some syphilitic taint. The right inguinal glands were enlarged, and four chancres existed in the left groin, one only of which was indurated ; others also existed about the vulva and anus. The cervix was small, normally placed ; the os surrounded by a chancre, partly covered with false membrane, similar to that met with in cases of croup. She was ordered proto-iodide of mercury, and alum injections and baths. On the 8th, she complained a good deal of headache, of uterine colic, and pains in the iliac fossæ. The chancres on the vulva were beginning to heal, the cervix was extremely tender, great pain on pressure in both lateral culs-de-sac, especially the right, but no distinct tumour could be discovered. There was much local heat, abdominal palpation was very painful. Twelve leeches were ordered to the right and eight to the left iliac fossa, followed by laudanum poultices. This gave some

relief; and on the 12th, twenty-five leeches were ordered to the hypogastrium, followed by mercurial inunction; the leeches bled freely, and gave great relief. During the next few days she had a severe attack of thoracic neuralgia; the mercurial treatment was continued, combined with quinine, and was successful. From Dec. 17th to the 28th the abdominal pains diminished, but there still remained great heat of the vagina; and behind the cervix, deeply placed, was a round, hard, painful tumour. There was a good deal of leucorrhœa, and the patient was beginning to be salivated. Chlorate of potash was ordered internally, and an alum gargle.

On the 6th of January, matters remained much the same, except that the tumour in the posterior cul-de-sac was found to be composed of two principal parts; one small, hard, round projection was placed directly behind the cervix—the other, larger, was situated posteriorly and to the left. She continued to improve gradually up to the 18th, when she insisted on going out; she caught cold, and was taken in the evening with rigors, followed by sharp pains in the right iliac fossa; but, on examination, the tumour in the posterior cul-de-sac was sensibly diminished.

On the 26th the following condition was noted; the cervix-uteri was inclined to the left, the tumour directly behind remained the same, while the rest had increased in size, and was harder and more painful. The part of the tumour situate on the left side seemed to involve the left broad ligament, and to extend to the iliac fossa, the ulceration in the cervix had healed. She was ordered quinine, pills of the extract of conium, to continue the iodide of mercury, blister to the left iliac fossa, and laudanum poultices. The pain continued to increase, and the retro-uterine tumour to enlarge in the right cul-de-sac.

On the 16th she was taken with shivering, nausea, vomiting, and severe pelvic pains, great febrile disturbance, and extreme tenderness on pressure over the abdomen. Leeches were applied to the right iliac fossa, which bled freely, and gave great relief; the tumours sensibly diminished, especially on the left; the same mercurial treatment with sedatives and rest was repeated. She continued to improve, with some slight drawbacks.

On the 3rd of April menstruation, which had been absent since August, came on, and passed off without any inconvenience. On examination afterwards, the retro-uterine tumour had almost disappeared, the principal part remaining being in the left cul-de-sac, separate from the cervix.

On the 15th of April it was noted that the vagina was of normal colour, all ulceration had healed, a slight swelling was distinguishable posteriorly to the left, but none elsewhere. All pain had disappeared, but the patient was very anæmic when she left the Hospital.

The apparently exceptional character of the preceding case, and my inability for want of space to record another case in which pelvi-peritonitis was developed in the course of a diphtheritic chancre of the cervix, makes it necessary that I should make a few remarks. I should add that cases of this kind, though rare, are by no means isolated; that the inflammation of the pelvic serous membrane cannot, under such circumstances, reasonably be attributed to a specific uterolumbar lymphitis, nor can it be regarded as the result of any kind of intra-pelvic bubo.

To determine this question, it is only necessary to compare these two cases with those of chancre of the cervix observed at *Lourcine*, in the course of two years and a-half; and to point out the circumstances connected with pelvi-peritonitis in these cases. From the twenty-four cases of chancre of the cervix of different varieties which I have met with, there are but two in which I have seen inflammation of the peritoneum connected with that ulceration; consequently, this accident, though not impossible, is very rare. In two other cases I have met with pelvi-peritonitis, but in one it was attributable to abortion (Case XV.), and in another, which I have not been able to report, to menstruation. In the twenty other cases, not only were there no signs of peritonitis, but there were not even any sympathetic signs of the chancre in the lumbar ganglia; while, on the contrary, the inguinal ganglia were affected in almost every case; hence it results that pelvic angio-leucitis, if it exists at all, is abnormal, and requires for its admission to be demonstrated anatomically. I do not deny the possibility of a uterine chancre reacting upon the lumbar ganglia; but I believe that, how certain soever this may be, we cannot regard inflammation of the pelvic peritoneum occurring in the course of chancrous ulceration of the ostinæ as produceable from intra-pelvic lymphitis.

It seems to me far easier, to admit that ulceration of the cervix, irrespective of any specific character, gives rise to a morbid condition of the uterine mucous membrane, which is propagated by simple continuity of structure to the tubar-mucous membrane, and thence to the peritoneum. The admission of this inflammatory process,

which resembles that observed in blennorrhagia, seems a legitimate explanation, when we consider the extent of the ulceration in cases of a diphtheritic character, and these are the only ones where I have met with pelvi-peritonitis. It seems further corroborated by the period at which the inflammation begins; viz., at the commencement of the process of forming false membrane, when there is the greatest inflammatory activity in the chancrous ulceration. Lastly, and more especially, this view is supported—First, by the existence of a morbid secretion from the uterine cavity, in all the cases where peritoneal inflammation occurred in the course of cervical ulceration, whether that ulceration were blennorrhagic, syphilitic, or any other kind. Secondly, by the variation of the secretion in the acute or declining period of the peritonitis. Thirdly, by the modifications which that secretion undergoes, wherever the peritoneal inflammation either increased or diminished in severity. In fact, the constant pre-existence of a morbid hyper-secretion of the uterus, with ulceration of the cervix, at the commencement of the pelvi-peritonitis; its diminution, viscosity, or puriform aspect, in the period of its greatest severity; and its great abundance and fluidity in the declining stage, all these go to prove that some intimate correlation exists between the ulceration, the mucous inflammation, and the peritonitis. This correlation seems to show what, under these circumstances, is the nature of the morbid process, that the inflammation is propagated from the more superficial to the deeper parts, and that every exacerbation in the pelvi-peritonitis is related to similar aggravation in the utero-tubar affection. Hence we can understand how a process so apparently inoffensive as the cold uterine douche, or even a digital examination, may, by exciting the inflammatory process of ulceration, give rise to the development of pelvi-peritonitis, as is exemplified in the following case.

CASE XVII.—*Syphilitic ulceration of the cervix and palate, aggravated by mercurial treatment; pelvi-peritonitis from the application of cold; increased by menstruation; gradual diminution of the retro-uterine tumour. Cure.*

E. L., age 22, was admitted into *Lourcine*, May 29th, 1855. Has had three children; began to menstruate at 16; has continued regular ever since; has been badly fed the last two years. In Oct., 1854, she was admitted into *Lourcine* for primary syphilis, having several indurated chancres on the vulva, and an ulcer on the cervix.

For this she was treated with mercury to salivation, but she left the Hospital before being cured. She was re-admitted in March, 1855. In February menstruation had been very slight, but there was no pain; after this there was a good deal of yellow discharge, and difficult micturition; for this she was re-admitted. Her general health had much improved since she left the Hospital, and there was no trace of syphilis. She complained of slight abdominal pain after menstruation in March, which was very scanty, but this was not increased by pressure in either cul-de-sac, both of which were healthy. There was still ulceration about the cervix, all round the os, from which proceeded some thick, glairy, yellow, muco-purulent discharge. Tonics, local and general, were administered, and nitrate of silver to the ulceration. The period in March was three weeks late, was preceded by a great deal of pain, for which leeches were applied to the right iliac fossa; after this she recovered, and left the Hospital in April. The ulceration of the cervix, however, remained partly covered with false membrane, which extended into the cervical cavity. After seven weeks' absence, during which she led the life of a prostitute, she was re-admitted on the 29th of May, 1855. During her absence, menstruation had occurred normally, she had been badly fed, and lived so irregularly that her general health was much deteriorated, but there was little or no evidence of constitutional syphilis. The cervix was elongated, conical, normally placed, containing some fungous ulceration covered with false membrane. Solution of nitrate of silver was applied, alum injections, baths, and mercury.

On the 8th of June, matters remaining in much the same condition, a cold douche was ordered, immediately after which abdominal and pelvic pains came on, and increased in severity towards evening. Next day, there was a good deal of fever, and pain over the lower part of the body, which was aggravated by pressure, but there was no nausea, vomiting, or rigors. The vagina was hot and very painful to the touch. Twenty leeches were applied to the iliac fossæ, and in the evening she had two rigors.

On the 11th she was somewhat better; there was less pain and fever; no swelling could be felt in either iliac fossa; in the posterior cul-de-sac a tumour could be distinctly felt, of the shape represented in the annexed sketch (Fig. 7).

This tumour was tender on pressure, and placed immediately behind the cervix, which it pushed against the pubis; it did not encroach upon the lateral culs-de-sac. It was rounded, somewhat hard, and

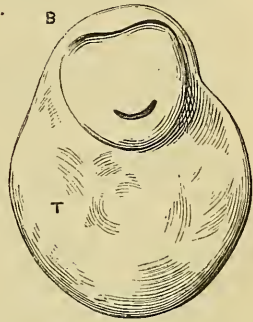
seemed composed of a number of smaller tumours. She was ordered mercury pills (of Dupuytren), baths, poultices, and rest.

On the 16th she was no better, had had slight rigors, and the abdominal tenderness had extended all over, but was worst in the iliac fossæ. Defæcation and micturition were painful, the tumour had increased rather than otherwise, the cervix being jammed against the pubis, and the rectum flattened, the tumour between the two being of great size. The os was patulous, and surrounded with granular ulceration of a deep red colour.

On the 30th of June the retro-uterine tumour had sensibly diminished, and the tenderness was principally limited to the right side; there was much less fever, and the rigors had ceased, but there was some tenderness in both lateral culs-de-sac. The cervix deviated from left to right, and was lower. The finger could pass between the cervix and pubis, where the anterior cul-de-sac was felt to be free, except that on deep pressure an indistinct kind of flattened ridge could be felt at the junction of the cervix with the body of the uterus. Posteriorly, the tumour could be felt distinctly separate from the cervix, and involving more of the lateral culs-de-sac than before; defæcation still painful; no ulceration of the cervix. She improved so much that she got up on the 7th of July.

On the 13th the fundus uteri could be felt in the left iliac fossa, and a tumour was distinguishable in that situation, adhering posteriorly to the right angle of the fundus. Both lateral and anterior culs-de-sac were free; the tumour in the posterior cul-de-sac was divided into three parts by vertical grooves. It was but slightly tender to the touch. She left the Hospital on the 14th. Since then she has been three times under my care, and I learned that the pelvic pains gradually diminished; leucorrhœa, which was profuse, diminished with the pain; the uterus regained its normal position, and only some induration was felt in the posterior cul-de-sac. Later still, even this disappeared, and some peri-uterine bands were felt, in the midst of which were some small knots—which, under the influence of menstruation, increased and became painful. Subsequently the uterus was slightly ante-flexed.

FIG. 7.



In March, 1856, this ante-flexion was much increased. The fundus uteri was bound by adhesions to its abnormal position. Menstruation became very painful, but no peri-uterine tumours could be felt at the time. The ulceration of the cervix alternately healed and re-appeared, and some abscesses formed in the glands about the vulva and groins. She left the Hospital for the last time, April, 1856, since when I have not seen her.

Notwithstanding the great length and interest of this case, in which I have endeavoured to show the singular appearance of the ulceration from which this woman suffered, and which has been regarded as of a scorbutic character, I cannot longer dwell on this subject. I shall, however, discuss it in another work, not only for the purpose of showing the similarity between ulceration of the gums, of the soft palate, and of the uterus, but also the resemblance in the pseudo-membranous productions which cover them. At the same time, I shall consider the evil results of a mercurial plan of treatment in these several instances. I can only now allude to these interesting peculiarities, as they will be considered in tracing the differential diagnosis of herpes of the cervix, and of diphtheritic chancres, or diphtheria, a kind of psoriasis of the uterine mucous membrane; which is remarkable, not only for the epithelial product which is its characteristic feature, but for its desperate incurability. Not to travel from my present subject—I have only now to seek out the cause or causes of the peritonitis which resulted immediately from the administration of a cold vaginal douche—whether it was to that and that only we should attribute the inflammation, or whether it was not connected with the cervico-uterine affection of which the ulceration was, as it were, only an efflorescence; or, lastly, whether it arose from the hypertrophy of the infra-vaginal portion of the cervix. Further, I must discover whether the orchitis was not, in the last case, produced by these three causes combined; and, if so, what was the part played by each in the genesis of the peritoneal affection.

This last idea appears to me to flow from a circumstantial analysis of the case. The absence of all sign of pelvic tumour prior to the 8th of June; the absence of any symptom of peritonitis or abdominal pain, not only before the patient had her bath, but even during the employment of the douche itself, and on the other hand, the sudden accession of pain immediately afterwards, seems clearly to prove that mischief was inflicted by the douche. Hence the

belief that this remedy may be an occasional cause of peritonitis, where there exists also inflammation of the tubes; and that, under the influence of slight excitement of the genital organs, as after a simple vaginal examination (*vide* Note) * rapidly fatal peritonitis may come on.

I believe, however, that such a result can only be regarded as very exceptional. The mischief which existed in M. Chipault's case about the cervico-uterine region, and which extended to the cervix in the form of ulceration, must not be overlooked. The severity of the inflammation after the douche, in Case XVII., evidenced in the alteration of the secretion, appears to me to have had a direct influence upon the development of the pelvi-peritonitis. It is but natural to suppose that the cervico-uterine affection, either by simple continuity of tissue, or by contiguity of part, was the starting-point of the peritoneal inflammation, excited, perhaps, by an ill-advised treatment.

I cannot attribute much to the cervical hypertrophy, notwithstanding that, as a result of this alteration in nutrition, we do sometimes get pelvi-peritonitis,† sometimes even fatal peritonitis,‡ but in this case the hypertrophic *allongement* was but slight, and had not previously occasioned any functional disturbance. All that can be attributed to this hypertrophy, and even this is quite arbitrary, is that it may have favoured the development, or have encouraged the

* Case of M. A. Chipault:—

V. C., aged 33, was admitted into *La Pitié* February 19th, 1861, suffering from cancer of the cervix uteri. Six days after her admission into the Hospital, during which time no active treatment of any kind had been resorted to, she was seized with sub-acute peritonitis, which came on three hours after a second examination, which was instituted with the view of determining the exact relations, etc., of the organic disease of the uterus. Three days after the commencement of this attack she died. On making a *post-mortem* examination, there was found to be very general purulent peritonitis; and on examining carefully, a small perforation of the left Fallopian tube was discovered, the fimbriated extremity of which was obliterated, and the tube itself distended with pus. The right tube was similarly distended; its fimbriated extremity was also obliterated by old adhesions between the fimbriæ. The uterine mucous membrane was in a state of chronic inflammation. The encephaloid disease was entirely limited to the cervix.

† Huguier, *Des allongements hypertrophiques du col de l'uterus*, p. 91. Baillière. Paris, 1860.

‡ Huguier, *loc. cit.* Case xiv. Case xvi. Case xix.

persistence of the cervico-uterine affection ; consequently, even with this supposition, the alteration in the nutrition of the cervix could only be regarded as a remote cause of the peritonitis. In one of the cases of peritonitis (*vide* Note)* reported by M. Huguier as ending fatally in a woman suffering from considerable *allongement*, the inflammation came on after an examination in which the sound was used. The result in that case was apparent immediately after the catheterism ; no sign of inflammation existing previously. I have witnessed the same results myself in several instances, of which the following case is an example :

CASE XVIII.—*Blenorrhagia of three months duration ; followed by pelvic pains symptomatic of pelvi-peritonitis ; admission into the Hospital for continued contagious discharge ; acute ante-flexion, replacement by the uterine sound ; symptoms of pelvic inflammation, and formation of a deposit in anterior cul-de-sac ; then of left ditto ; aggravated by menstruation ; gradual recovery ; sexual intercourse followed by renewal of the pelvi-peritonitis ; cure.*

G. L., aged 18, was admitted into *Lourcine* on the 5th of March, 1855. She had not enjoyed very good health in early life. At 14½ menstruation came on without pain, but was scanty, and preceded by a good deal of leucorrhœa ; from that time till she was 16 years old the periods were quite regular, but scanty and pale. At 16 she had sexual intercourse for the first time, after which the periods were freer, without pain. At 17 the periods became irregular and tardy.

In May, 1855, she, for the first time, contracted a venereal disease ; and in July she suffered rather severe pain in the pelvis, which was

* Case of Mr. Huguier, *loc. cit.* Obs. xvi. p. 111 :—

V. M., aged 65, was admitted into the *Hôpital Beaujon*, February 3rd, 1857. Married, and had nine children. Had suffered from prolapsus uteri for many years, and for the last four years from proclidentia. The lowest portion of the proclident organ was ulcerated, and had been so for some months. The vagina was completely inverted. The sound at first only passed about 3½ inches into the uterus, leaving a considerable portion of the uterus above. After some little manipulation the sound entered 0.125. On the 7th of February, four days after the examination, symptoms of peritonitis came on, for which leeches were applied, then blisters, mercury, opium, etc., but she got worse and died on the 12th.

On *post-mortem* examination, there was found to be general peritonitis, slightly purulent, with adhesion of the different viscera. The uterus was a good deal elongated, and measured 0.155 ; it was also, much hypertrophied.

continued in the following periods. For all this, she did nothing but use alum injections; and, finding that she derived no benefit, she was admitted into *Lourcine*, March the 6th, 1856, when the following was noted as her condition.

There was no evidence of constitutional syphilitic taint, no enlargement of inguinal glands, the vulva were quite healthy, but a good deal of thick, white discharge came from the vagina. The cervix was directed backwards, the uterus anteflexed somewhat acutely, and on introducing the sound it passed readily for about $1\frac{1}{2}$ inches, when it was arrested, its further progress causing some pain; it was, however, pushed on gently for about $2\frac{3}{4}$ inches, the uterus meanwhile being carefully replaced. The examination caused pain, for which a warm bath was ordered; but while in the bath severe lumbar and hypogastric pains came on, and were followed by a slight bloody discharge, which was thought to be menstrual; it continued very scantily for three days, accompanied by acute pain and some febrile disturbance.

On the 11th the discharge ceased, or was exchanged for one of a yellowish viscid character, the pain still continuing.

On the 12th much the same, the vagina and cervix were observed to be of a deep red colour, the latter almost violet; but no deposit, swelling, or enlargement was anywhere discoverable. In the next few days the lumbar pains subsided, while those in the hypogastrium increased, especially on walking or on pressure. They were limited entirely to the cervical region, not extending either to the iliac fossæ or to the thighs; the discharge also increased.

This state of things continued up to the 17th of May, when a firm, hard ridge of deposit was detected at about the level of the

On the right side all its appendages were normal; but on the left side it was quite round and smooth, being covered with peritoneum, and entirely deficient of all ligament, ovary, or Fallopian tube. On opening the uterus it was seen to be divided into two parts by a thin transparent membrane, which extended from the fundus to the cervix antero-posteriorly. The cavity on the right was very large; that on the left much smaller—and here the sound had entered. It seemed evident that the smaller cavity corresponded with the left horn of the uterus, which was arrested in its development by the absence of the corresponding ovary. The absence of the ligaments, on that side, I do not consider had anything to do with the prolapse, as those on the right were entire. It may be added, that the left supra-renal capsule was absent, and the kidney displaced. Also, that though there was but one ovary, the patient had had nine children of both sexes.

internal os, extending from right to left, and not separable from the uterus by any groove. It was extremely painful to the touch; and any movement of the uterus also caused pain, especially that of elevation. The cervix was tender, deeply injected, not ulcerated; and from the os thick, glairy mucus was proceeding. No other swelling was felt in any of the other culs-de-sac. She was ordered quinine, iodide of iron, poultices to the abdomen, and baths twice a week.

From the 18th to the 25th of May, the pains and discharge continued, and the general and local condition remained much as before, except that the swelling in the anterior cul-de-sac was more distinctly defined, and was separated from the cervix by a groove; it was also somewhat increased in size, extending towards the left border of the uterus, and by external examination it was felt to be about on a level with the fundus uteri. In the right cul-de-sac a round, resisting, transverse band could be felt extending from the right border of the fundus uteri to the corresponding broad ligament.

From May the 25th to June the 13th the pains diminished somewhat, and were limited to the sub-pubic region and to the iliac fossæ, especially the left. They were increased whenever she attempted to get up, which she had not done since the sound was used on the 7th of March, or when any examination was made. As the discharge still continued, a nitrate of silver injection was ordered to be used; and on the 21st of June it was noted that the tumour was sensibly diminished; that in the left cul-de-sac was of oval form, less hard, and more detached from the uterus; the discharge still continued.

From this date to the 16th of July the pains gradually diminished, but the vaginal examination revealed no change. The uterine discharge remained the same, but the vaginal discharge was greatly relieved by the nitrate of silver injection. She was ordered iodide of iron, quinine wine, poultices, and rest.

On the 17th she was taken with sharp pains in the thighs and right iliac fossa, the uterus was almost fixed, the ridge before spoken of as situate on a level with the internal os remained about the same, but the tumours in the lateral culs-de-sac were increased in size and more tender. Believing that this recurrence of the symptoms indicated the approach of menstruation, four leeches were applied to the upper and inner part of the thighs, and a warm bath ordered each day.

On the 22nd, there being no improvement, a large cautery was applied to the swellings in the iliac fossæ. The pains, however, increased, and became violent after standing for a time.

On the 26th, the swellings were much more tender, and greatly increased in size, especially that on the right—rising up in the abdomen the width of the hand above the pubis, and projecting into the corresponding vaginal cul-de-sac. The cervix and vagina still presented a normal appearance, the discharge continued the same. From this time to the 4th of Aug., the tumours gradually diminished, but menstruation did not come on. At the end of August the tumour on the right side was reduced to the size of a large nut, which hung by a thin, short, pedicle to the upper right angle of the uterus. It was extremely tender to the touch, and produced when pressed peculiar sensations; that on the left was also tender, but had not this peculiar sensibility; it also adhered to the left border of the uterus. The uterus itself was smaller, still almost immovable, and excessively painful if moved; the examination generally caused much less pain than before.

On the 26th, menstruation came on scantily and with less pain.

From the 15th of Sept. to the 1st of Nov. the patient continued much the same in her general and local condition.

On the 16th of Nov., and again on the 13th of Dec., after some pain resembling dysmenorrhœa, small masses of glairy mucus were expelled, apparently in the place of ordinary menstruation, and each time with marked relief.

On 26th of Dec. menstruation came on only for a day and half, notwithstanding that leeches were applied to the thighs; she, however, felt relieved by it. During the month of January no perceptible change was noticed in the tumours. The vaginal discharge stopped under the influence of tannin.

On the 6th of Feb. menstruation came on without any pain, and lasted a day and a half.

On the 4th of March she left the Hospital.

On the 12th she returned, complaining of a good deal of pain of a lancinating character occurring at intervals. The tumours had sensibly increased since she left the Hospital. She was ordered baths, poultices, and rest; and in a few days all pain had completely disappeared. The tumours were smaller and less tense. I did not see this patient again till Nov. the 8th, when I learned that the pain had gradually left her, that in May menstruation appeared freely and

lasted four or five days, and recurred regularly afterwards until October; when, after some fatigue and the want of proper food, it returned for two days only, and was followed by a leucorrhœal discharge.

On examination the vagina and cervix appeared to be normal, the ante-flexion remained, though less acutely. A round, soft, indolent tumour, the size of a nut, hung by a pedicle from the right angle of the uterus; on the left border was a similar tumour, the size of a large filbert. She was ordered syrup of the iodide of iron, and an astringent injection.

On the 17th, menstruation came on, and lasted four days. She left the Hospital on Dec. 1, and I have not seen her since.

It is clear that the phenomena which occurred in this case cannot all be attributed to the employment of the sound. There must have been some predisposing cause, in addition to the circumstances which immediately called forth the symptoms, and which were in existence upwards of a year. Immediately after the examination, as in the two cases related below,* the uterus became tender to the touch; and, while in the bath, which was ordered immediately, to diminish this uterine excitement, the patient first experienced the hypogastric pains, which afterwards became persistent. On leaving the bath, a discharge

* Case of M. Noël Gueneau de Mussy, from the report of M. Depaul, made to the *Academy of Medicine*, on the treatment of uterine deviations by intra-uterine pessaries.

A woman was admitted into the *Hôpital St. Antoine* for retro-flexion and prolapsus uteri, with granular erosion of the cervix. The uterus could easily be replaced by the sound of Huguier without pain; but was immediately followed by peritonitis, and she died in three or four days. As a *post-mortem* examination was refused by the friends, the uterus was removed per vaginam by the plan of Recamier, and on the peritoneal cavity being opened, some blood and pus flowed out. The uterus was healthy, but the Fallopian tubes contained a little bloody effusion.

Case of Dr. Oldham, extracted from the same Report of M. Depaul.

A lady, aged 36, had been married several years, was sterile, and suffered from dysmenorrhœa. For this she came to London to have the uterus dilated, which was done, she said, with silver instruments, which caused her very great pain. After one of these proceedings, she was seized with an attack of peritonitis, from which, in a few days, she died. On *post-mortem* examination there was found very extensive and severe peritonitis, which, however, was entirely limited to the pelvic peritoneum. All the generative organs were very vascular, and two small fibroids existed in the anterior wall of the uterus.

of blood took place, followed by a muco-purulent discharge, which continued for upwards of ten months, none of which existed previous to the employment of the sound. The sudden appearance of the symptoms leaves no room for doubt; it proves clearly, I think, that they were occasioned by the sound, but it suggests at the same time the idea that there were predisposing causes which rendered this ordinarily innocent examination the occasion for the development of morbid phenomena. Among these predisposing causes may be reckoned the blenorragia which, in all probability, was not limited to the vagina, but had involved the uterine cavity three months after it began, as evidenced by the hypogastric pains and the dysmenorrhœa which succeeded them. We can readily understand that this affection, though scarcely appreciable at the time of the catheterism, rendered the mucous membrane more liable to new inflammatory action; and this was not the only result of this blenorragia; its influence upon the peritoneum had caused that angular inflexion, the redressing of which by the sound led to such sad results. In fact, the consideration of the symptoms, and their relation to each other, seems to show that the catheterism occasioned the rupture of some fibrous bands, and this became, as it were, the starting-point of the subsequent pelvi-peritonitis. The junction of the cervix with the body of the uterus, being the point of greatest flexion, offered a certain resistance to the introduction of the sound; and, immediately after its reduction, it became very painful to the touch. It was at this point that, after some days of suffering, the first peri-uterine induration occurred; and, like all peritoneal thickening, it was only perceptible after the serous inflammation had reached the stage of the production of false membranes. It was from this point afterwards that the peritoneal inflammation advanced step by step, first to the left border of the uterus, then to the corresponding cul-de-sac, and lastly to the right cul-de-sac. These several circumstances appear to prove the proposition stated above.

But even admitting that the peritonitis was thus produced, it still does not account either for the extension or for the chronic character of the inflammation. The former, favoured probably by the previous existence of a similar affection, which set in three months after the commencement of the discharge and nine months prior to the catheterism, appears to me to have been due entirely to the reaction upon the peritoneum of the catarrhal metritis resulting from the examination. I shall not attempt to determine whether the catarrhal

metritis which immediately succeeded the employment of the sound was simply a return of the acute stage, or was the result of a fresh extension of the blenorragia to the uterus; or, lastly, whether it was a local manifestation of a scrofulous taint. It seems more probable that the blenorragia again invaded the uterus after the catheterism; and that the scrofulous diathesis perpetuated, as it were, both the blenorragic and the catarrhal metritis. The nature of this last is comparatively of little importance; what more concerns our present subject is the connection between the long duration of the disease and the constitutional condition of the patient. No doubt the catarrhal metritis stamped on the pelvi-peritonitis its chronic character. It is interesting, also, to note that each of the peritoneal swellings resulted from a recrudescence of the uterine affection, the periodicity of which seems to connect them with the menstrual molimen which took place, although nothing was seen externally. It is still more important to observe, that the slow improvement in the pelvi-peritonitis came on only after the uterine affection itself had abated, and when menstruation was established.

I ought, however, to notice the beneficial results which seemed to follow the employment of nitrate of silver; this I ordered unwillingly, and only in accordance with the wishes of the patient, but it seemed to exercise a beneficial revulsive action, similar to that which M. Aran sought to obtain from the application of blisters to the cervix itself. There is one point, to which I must direct special attention, viz., that the definitive cure was obtained only when, discouraged by the long persistence of the pains, I advised the patient to leave the Hospital, being persuaded that when free she would indulge in sexual intercourse, and this would exercise a beneficial effect, similar to that which happens in the chronic stage of orchitis in the male. As an example of this benefit I may refer to Case XVII., where the patient, against my consent, left the Hospital just when the peri-uterine tumour began to be absorbed; and not only did the improvement continue, but it even increased in greater proportion. I need not dwell further on this subject, because I shall have to refer to it again in the chapter on Treatment.

CHAPTER III.

SYMPTOMATOLOGY.

1. *Acute sero-adhesive Pelvi-peritonitis.*

THE symptomatology of pelvi-peritonitis presents many difficulties; partly because, except in those cases where it is of traumatic origin, it follows upon some affection of the intra-pelvic organs, partly because in almost every case there are uterine deviations. It is necessary, therefore, to determine what belongs to the several morbid conditions, so as not to attribute to one what properly belongs to another, especially in reference to the displacements, which do not give rise to any pain, unless under exceptional circumstances, as we shall see in the succeeding memoir. On the other hand, pain is the prominent symptom of pelvi-peritonitis, as it is of all kinds of serous inflammation.

We ought, in order to give a complete sketch of the symptoms of pelvi-peritonitis, to study successively its several varieties, puerperal, menstrual, blenorrhagic, venereal, traumatic, &c.; and not only this, but each of the varieties of these. All this, however, would occupy so much space, that I am compelled to forego it; but in the chapter on Treatment, I shall dwell more fully upon the indications resulting from these differences, which now I can only briefly refer to.

This exposition, like all dogmatic descriptions, will only contain an account of the symptoms of pelvi-peritonitis proper, whether puerperal, blenorrhagic, &c., and the only distinction I shall now make is between the acute and chronic varieties.

In the acute form, the patient, either without any premonitory symptoms, when the pelvi-peritonitis is traumatic (Case XVIII.), or after some days of malaise, during which there is a feeling of weight in the pelvis, is suddenly seized with severe abdominal pain, varying in different cases both in extent and severity, but so peculiar and so well known that it is unnecessary to describe it. Sometimes it radiates from the hypogastric to the abdominal region; sometimes it is limited to one or both iliac fossæ; and always there is difficult

micturition and defæcation with pain down one or other thigh. In one case, which came under my notice in March, 1861, there was no pain whatever; though the case was one of general suppurative peritonitis, which terminated fatally a month after the menstrual suppression which occasioned it, and was accompanied by very grave symptoms, stupor, prostration, diarrhœa, and continued fever, but without any rose rash. The pain is usually increased by deep inspirations, cough, movements of the legs, tension of the abdominal muscles, and especially by pressure. In consequence of this, examination of the parts is almost impossible; and equally difficult is it to demonstrate the existence of any tumour, either in the iliac fossæ, or in the vaginal culs-de-sac, which are sometimes the most painful of all. The uterus, any movement of which causes extreme suffering either in the hypogastric region or in the iliac fossæ, maintains its usual position; any deviation takes place later, when the tumefaction in the vaginal culs-de-sac occurs, and false membranes are being formed.

But, before any swelling appears, in the greater number of cases, where the attack does not end speedily by suppurative inflammation, as in Case III., an improvement of the general symptoms is apparent; these symptoms are, an anxious expression, nausea, vomiting, constipation, or diarrhœa, quick small pulse, and dry but not hot skin. In some cases these are constant phenomena, in others they are hardly recognisable. The fever is sometimes indicated only by slight increase of the pulse most marked at night, sometimes it is preceded by slight rigor, at other times by well-marked shivering, and lastly by a state of languor and weakness, which it is important to recognise as it is a cause of much error in diagnosis. When the febrile reaction diminishes, the abdominal pain becomes less, either from the treatment or spontaneously. From this, and from the tendency of the inflammation to take on the adhesive form, or to lead to the effusion of serum or pus, we find sometimes at the first examination a swelling in one or more vaginal culs-de-sac, at other times only a sort of vague resistance is felt. It happens sometimes that after a first or even a second examination, the day after nothing is discovered except some tenderness; but the next day, perhaps, a peri-uterine tumour is felt. This occurred in Cases III., IX., XVI., XVII., XVIII. It is necessary to insist on this point; because sometimes the practitioner finding one day what he had not discovered by examination perhaps the day before; and again on the succeeding day finding that the tumour is quite different to what it was when first made out, doubts the value of a

mode of examination which it is of course as necessary to familiarise oneself with as with auscultation.

This idea of a tumour which may be felt in one or more of the vaginal culs-de-sac is all the more interesting, because, as a sign of pelvi-peritonitis, it is analogous to the dulness, or rather the want of elasticity in percussion which exists in pleurisy, and is one of the most important elements in diagnosis. Unfortunately, there are many impressions derived from examinations which depend on the sensibility of the practitioner, and which it is impossible to communicate to those who have not that special tact without which no uterine disease can be diagnosed. But I am not writing for those who are so utterly ignorant on these points. The tumour in question is in close apposition to the uterus, but not actually one with it—a point which it is important to determine, because it shuts out all idea of its being a case of partial or general enlargement of the uterus itself, such as is sometimes met with. It is separated from the uterus by a more or less distinct groove; but its independence of the uterus is better recognised by its different consistence and elasticity, and by its configuration. Limited to a greater or less extent by the circumference of the uterus, the tumour always leaves one, or at least a part of one of the vaginal culs-de-sac free; these ought, therefore, to be most carefully explored per vaginam and by abdominal palpation combined. By this comparative examination of all the vaginal culs-de-sac, not only can the existence and dimensions of the tumour be made out; but the extent of the uterus also, which is free from the tumour, can be discovered; as well as the various displacements, flexions, versions, or rotations which the uterus has undergone. On pressing the finger deeply on the part of the vaginal cul-de-sac not occupied by the tumour, we can pretty clearly make out by comparative measurement the repletion of the surrounding parts; we can also examine the surfaces and borders of the uterus, to see if there be any flexion. Great care is necessary in this part of the examination, as we may easily mistake a flexion for a peri-uterine tumour. The examination of the uninvaded cul-de-sac shows not only its depth, but also whether it is increased or diminished in either direction by the uterus being displaced by the tumour. This point is the more interesting, because the displacements vary, not only in direction, but also as regards the amount of space occupied. Thus the tumour may displace the uterus entirely, cervix and body, without causing any version, by a kind of pressure exercised equally on

the two parts of the organ. In the case (XII.) represented in Fig. 8,

FIG. 8.

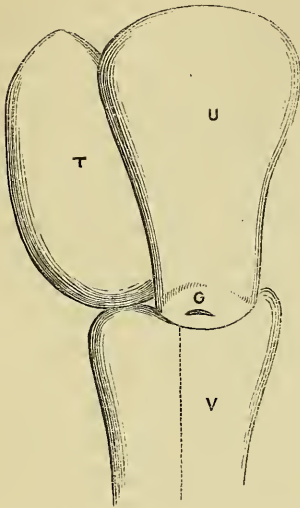
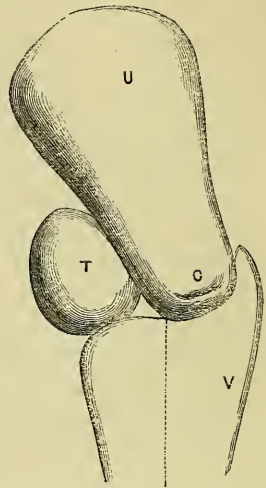


FIG. 9.



U. Uterus. C. Cervix. T. Tumour.
V. Axis of vagina.

U. Uterus. C. Cervix. T. Tumour.
V. Axis of vagina.

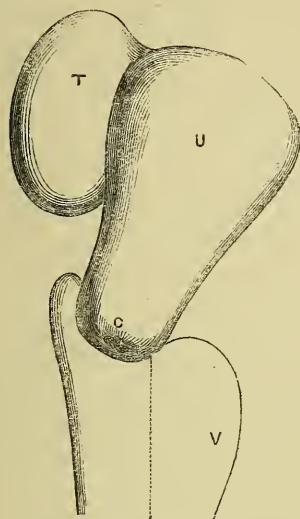
which is the rarest form, we find the cul-de-sac occupied by the tumour, not only wider, but shallower than that on the opposite side. We also find that the uterus is sometimes so twisted, that the cervix is drawn away from the cul-de-sac in which the tumour is situated and looks to the opposite side, while the fundus uteri is inclined to the iliac fossa of the affected side (*vide* Case XIII.) This latero-rotation which is the most frequent of all the displacements produced in the acute stage of pelvi-peritonitis, and which is represented in Fig. 9, is rarely simple; it is almost constantly associated with a slight inclination of the fundus backwards, together with some rotation of the organ on its axis which carries forwards the corresponding border of the tumour.

In Fig. 10, the cervix, instead of being pushed away by the tumour, seems drawn into the affected cul-de-sac; which, in this case, is deeper than that of the healthy side, and seems narrower below, so as to widen a little at the junction of the cervix with the body of the uterus, where we generally find the peritoneal induration, by its exclusive action on the body of the uterus pushes it towards the healthy iliac fossa (*vide* Case XV.)

It must be understood that the displacements just described are

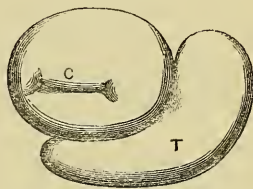
those witnessed in spurious peri-uterine latero-phlegmons, which are by far the most frequent, especially if we include under this name those which occupy the three posterior quarters of one of the lateral

FIG. 10.



U. Uterus. C. Cervix. T. Tumour.
V. Axis of vagina.

FIG. 11.



C. Cervix. T. Tumour.

culs-de-sac; and, at the same time, the corresponding half of the posterior cul-de-sac, as is represented in Fig. 11.

This latero-posterior part of the uterine circumference, and more frequently the left than the right side of it, is the chosen seat of those tumours to which pelvi-peritonitis gives rise.*

We come now to the spurious peri-uterine retro-phlegmons, which are less common than the others. They occupy, generally, only the posterior cul-de-sac, with their centre directly behind the neck, displacing this organ in a double direction, and pushing it downwards and forwards.†

It is necessary to insist upon this point, because the tumour, by its position behind the uterus, its descent below it, its extension into one or both of the lateral culs-de-sac, (which latter is the more frequent), and by its configuration, strikingly resembles the swelling of hæmatocele. I also specially insist on the projection of the cervix forwards and upwards by the retro-uterine tumour, as symptomatic

* Vide cases i., vii., ix., xiii.

† Vide cases ii., xvi., xvii.

of sero-albuminous or purulent pelvi-peritonitis, because the incorrect interpretation of this displacement has been the cause of many errors of diagnosis.

The spurious peri-uterine ante-phlegmons, which are the rarest of all forms, may, by pushing the cervix backwards, be sometimes confounded with ante-flexions; or, perhaps, I ought rather to say that ante-flexions may be mistaken for ante-phlegmons. This mistake is easily made in some cases of first pregnancy, when the fundus uteri, sharply curved anteriorly, descends below the cervix, presenting itself to the examining finger larger and more elastic than the rest of the organ. For the diagnosis of this condition, we must examine very carefully the borders of the uterus, and note the different intrinsic characters of the peri-uterine tumour, which I will now detail.

That these tumours resemble each other by their phlegmonous character, I need scarcely say; and I should still have a difficulty in distinguishing them, had I not been forced by circumstances to more careful examination. I shall not allude to the existence of arterial pulsations on their vaginal surface, especially at an advanced stage of their formation, because similar pulsations are met with in hæmatoceles, in organic diseases, and in long-standing morbid conditions which have led to permanent increase of the vessels at the base of the broad ligaments. But I must insist on the peculiar consistence and the constant variations in the form of the tumours caused by pelvi-peritonitis. They are preceded, as I have said, by a vague feeling of resistance, which is felt with difficulty in consequence of the pain: at first, they are not very thick, and are moulded by the form of the vaginal cul-de-sac. Their weight renders them convex inferiorly; they present a kind of elasticity, similar to that met with in the first stage of a phlegmon: more rarely there is a sense of false fluctuation, similar to that which exists round white swellings (*tumeurs blanches*). This elasticity quickly disappears, except in those rare cases where suppuration takes place. Then the tumour insensibly hardens, up to the time when resolution begins, which takes place from about the fifteenth to the twenty-first day from the commencement of the mischief, or after one or more exacerbations have taken place. As a general rule, these tumours can be felt only by vaginal examination; they do not rise sufficiently to be felt in the iliac fossæ, where only an indistinct fulness can be made out. At a later period, when they are increased in size by inflammatory

attacks, they present on their vaginal surface more or less distinct prominences which are hard, and may sometimes be felt projecting in the hypogastric region. By combining the two modes of examination, internal and external, we are able to estimate the thickness, the absence of fluctuation, and the almost fibro-cartilaginous hardness of these tumours. When, as is most frequently the case, they are placed laterally, they seem to form a kind of latero-posterior wing to the uterus. They rarely pass the superior limit of the pelvis; but when they do, it is seldom more than two or three fingers' width above the horizontal ramus of the pubis, from which they are separated by a slight interval. This last is an important point, because the intra-cavitar seat of these tumours is one of the elements in the differential diagnosis of phlegmons of the broad ligaments, which tend, on the contrary, in their progress, to invade the cellular tissue of the iliac fossa; so that the tumour which they form, when it emerges from the pelvis, is united to the abdominal wall itself. It is the more necessary to insist on this intra-cavitar position of peritoneal indurations, and on the mobility of the abdominal walls which glide over them, because phlegmons of the broad ligaments and pelvi-peritonitis not only often co-exist, but because they both sometimes, under the influence of the same causes, experience inflammatory exacerbations, which are so common in pelvi-peritonitis as almost to constitute one of its fundamental characters.

The most frequent causes of these exacerbations are, first, the menstrual molimen, especially when there is no proper discharge; and, secondly, bodily fatigue. At the same time, they may arise from other causes which are not appreciable. Sometimes they are produced by severe surgical interference. They are characterised by hypogastric pains, followed by intervals of ease, occupying sometimes one seat, sometimes another. As these pains are less than at the primary attack, and the general symptoms are also less severe, there is no rigor, nausea or vomiting; generally there is either constipation or diarrhœa, with but little appetite and some febrile reaction; the latter is seldom absent, and is accompanied by general malaise, quick pulse, and chilliness, especially in the evening.

While these events are taking place, there is a sensible increase in the size of the peri-uterine swelling, sometimes it invades the parts in the adjoining region, and sometimes the iliac fossa of the opposite side, which becomes the seat of severe pain. It is during these aggravations that the arterial pulsations, to which

M. Nonat has attributed a symptomatological importance which they do deserve, become so evident, especially if the tumour has at the same time become more markedly elastic. This last modification, which is far more important than the arterial pulsations, is accompanied by changes in regard to the uterine displacement which took place in the onset of the pelvi-peritonitis. These changes consist, either in an increase of the primary displacements; or in a rotatory movement of the uterus on its axis; or in a complete change of its position by version; or in a conversion of the original version into some other. The most frequent of all is the transference of the cervix from one cul-de-sac to another; so that having been removed from the tumour at first, it approximates it now, owing to the greater thickness of the induration, which pushes the fundus towards the healthy iliac fossa. These displacements are important, as affording the key to the various uterine deviations; and also because they serve to distinguish tumours produced by pelvi-peritonitis from fibrous tumours or ovarian cysts, which are not capable of such sudden and frequent changes. I shall have to return to this question hereafter.

The number of exacerbations which takes place varies a good deal, and depends partly on the severity of the peritoneal inflammation, partly on the nature of the affection of the uterus or its appendages which originated the peritonitis, and partly on the constitutional or acquired peculiarity of the patient. Sometimes the case may go on to the end without any exacerbation (*vide* Case VII.); and this is especially likely to happen when the inflammation begins lightly, and is caused by some accidental disturbance of menstruation. Sometimes, on the contrary, the mischief is prolonged almost indefinitely, to the despair alike of the patient and physician: this occurs more often in cases of puerperal pelvi-peritonitis, in chronic catarrhal metritis, blenorragic or scrofulous. But, whatever may be the disease which has originated the pelvi-peritonitis, it always has a tendency after a certain number of exacerbations to assume a chronic character; each exacerbation seeming, as it were, to prepare the way for a succeeding one—not only because that after each the tumour is left so much larger, but more particularly because the patient's debility increases, and becomes a serious obstacle to the cure.

In short, the cachectic condition which is induced not only exercises a bad influence upon the function of menstruation, the due performance of which is indeed indispensable to any permanent relief; but

it also makes the patient liable to the action of slight morbid causes. Hence, at this stage, the mere hysteralgic pains symptomatic of the anæmic condition of the patient, may become a cause of renewed peritoneal mischief; they resemble in this respect certain forms of gastralgia, or rather certain cases of chronic gastritis. Thus the anæmia, resulting partly from the inflammation and partly from the antiphlogistic treatment which has seemed necessary, becomes afterwards a cause of fresh attacks; these again aggravate the anæmia, and give rise to nervous hysteralgic pains, which produce fresh *fluxions* in the peri-uterine tumours. It is a sort of vicious circle, in which everything turns to the disadvantage of the patient.

I have entered thus lengthily into the character of these exacerbations, because they constitute an essential and distinguishing feature of this affection. They are, however, sometimes absent, or they occur very infrequently. I may add, in reference to the chronic character which the disease sometimes assumes, and the influence of blood-letting upon it, that after a time the hysteralgia becomes, to a great extent, a purely nervous phenomenon, contra-indicating very clearly the employment of depleting remedies. This point is of great importance, because it is often at this period that we are first consulted for the relief of the patient's sufferings; and only by a long and minute examination of the history of the case, can we arrive at any satisfactory opinion as to the present cause of suffering; without this, we may be led to adopt the very mistaken views advocated by some pathologists—who, seeing these pains which are symptomatic of pelvi-peritonitis associated with a uterine displacement, of the cause of which they are ignorant, attribute the pain to the displacement, and immediately resort to some mechanical treatment. Moreover, unless we are thoroughly acquainted with all the antecedents of the case, we may attribute to some uterine neurosis the pain which is really symptomatic of old standing inflammation; in this way I am persuaded that the frequency of the so-called *irritable uterus* has been largely exaggerated. I do not for a moment wish to dispute the existence of this affection, which, I suppose, is analogous to the irritable mamma and testicle; and, like these, it is, in the majority of cases, symptomatic of chlorosis, hypochondria, and more often of hysteria. All I want is to guard against the ascribing of the hysteralgic pains which occur in the later stages of pelvi-peritonitis, to any mere uterine neurosis, though they sometimes very closely resemble the pains of irritable uterus, and *vice versa*; just as toothache sometimes simulates tic douloureux.

The hysteralgic pains which occur in pelvi-peritonitis present this peculiarity, as compared with the pains of irritable uterus, that whether produced with no apparent cause, or by some moral or physical agent, or by the menstrual molimen, they always begin in the part of the pelvis where the peri-uterine tumour exists. From this point, as from a focus, they radiate towards the hypogastrium, to the lumbar region, to the anterior part of the tenth intercostal space—which, for some reason or other, I cannot explain why, is the spot to which uterine pains are reflected. They also radiate to the anterior and inner part of the thighs, to the point of exit of the sciatic nerve, and occasionally to all the parts supplied by this nerve. This kind of nervous exacerbation is further characterised by a kind of anxiety and restlessness, quite different to the almost absolute immobility of patients who are suffering from true inflammatory attacks. With these the least movement increases the pain, while, with the former, change of position seems, though only for a very short time, to give relief. The duration of the attack in the nervous variety varies a good deal, though the cause thereof is not easily made out. I can only say, though I cannot state this positively, that it would appear as if these pains were sometimes connected with small intra-pelvic encysted purulent collections, similar to those described in Case X. Where this is not the case, the hysteralgic pains of pelvi-peritonitis are certainly less severe than those of the irritable uterus; they are also less wandering, and less distinctly intermitting than those incidental to hysteria. There are, however, it must be admitted, cases where the existence of hysteria before the present illness complicates the symptoms by the addition of hysterical phenomena.

These hysteralgic pains, though they may be more or less influenced by a previously existing neurosis, or may result from the cachexia of long-continued disease, present the characters of nervous pain sufficiently well to be recognised. They are, for instance, moveable, sensibly modified by disturbing causes, and less enduring than the paroxysm of irritable uterus. This last accounts for the good results obtained by M. Nonat,* from slight cauterisations of the hypogastric and crural regions; a practice otherwise open to the objection of leaving eschars on the skin. It accounts also for the occasional success of the still more mischievous, because dangerous practice of cauterising the cervix, whether with the actual or potential cautery.

* Nonat, *loc. cit.* p. 303.

In like manner, we may attribute to the predominance of these nervous phenomena in the chronic periods of pelvi-peritonitis, the cures which result from hydrotherapeia, from salt water baths, from thermal waters of all kinds ; these all tend to improve the patient's general condition, and thus to remedy the cachexia upon which they depend. Hence also the benefit resulting from some mineral waters, by improving the diathesis to which the mischief is mainly due.

There is one very important point upon which I must make a few remarks, viz., the connection between the ulcerative conditions of the cervix uteri, and the metrorrhagia which often co-exists with pelvi-peritoneal inflammation.

The analysis of my cases proves very plainly, first, that a relation exists between cervical ulcerations and the uterine affection which is the starting-point of the pelvi-peritonitis ; and, secondly, the almost complete independence of the ulceration and the peritoneal inflammation ; the former being in no way produced by the latter. The first of these propositions is proved by the fact that in a certain proportion of cases no ulceration is discoverable ; in other cases there is a uniform co-existence of muco-purulent discharge with cervical ulceration ; and, thirdly, there is a difference in the appearance which the ulceration assumes, according to the nature of the disease which originated the uterine affection. In short, the absence of any ulceration in a certain number of cases of pelvi-peritonitis, menstrual in particular ; and the constant co-existence of muco-purulent discharge in cases of cervical ulceration, clearly establish an intimate connection between cervico-uterine ulceration, and the morbid secretion of the uterus. This point is yet further demonstrated by the special character of the ulceration in puerperal cases, in cases of blenorhagia, scrofula, &c. It shows that the ulcer is only the outward manifestation of a morbid condition of the cervico-uterine mucous membrane ; just as we get various ulcerations of the nares in the several varieties of coryza. So, then, this cervical ulceration is to be regarded merely as an accident of pelvi-peritonitis, at least, in its acute stage. I make this restriction, because it is impossible to deny that this affection has, at least, some indirect influence in the production of those cervical ulcerations which occur in the chronic stages of spurious peri-uterine phlegmons ; and this is especially the case in the anæmic conditions which result therefrom. Cachexia always predisposes to ulceration in those parts which are subject to sanguineous discharges.

On the other hand, metrorrhagia is so constant and so important a phenomenon of pelvi-peritonitis, that it cannot be regarded as an accidental occurrence; we must therefore determine at what period it is most likely to occur, under what circumstances, and what influence it exercises over the peritoneal affection.

My observations go to prove that these discharges may occur at any time in the course of pelvi-peritonitis,* especially if we include, as we ought, cases of excess in the menstrual or lochial discharges; but they are rare at the *period d'état* in comparison with their frequency at the extreme periods in the serous inflammation. In the intermediate period, the discharge is probably only a prolongation of the menstrual flow, intimately related to an increase in the severity of the inflammation. The division which I have pointed out of metrorrhagia occurring in the acute and chronic stage of the affection, indicates a difference in their causes; notwithstanding that, in both cases, they result from an afflux of blood to the genital organs caused by the disease itself.

The metrorrhagia which occurs in the acute stage, or after any exacerbation of the inflammatory attack, generally comes on at the close of the more severe symptoms when the pain is subsiding; the blood, though supplied both from the cervix and body of the uterus, flows so imperceptibly, and is so unaccompanied by pain, that the patient feels little of it. The case is quite different in the chronic form, where the discharge is often accompanied by painful uterine contractions. In the majority of cases of the acute variety, the blood flows *guttatim* from the open os; and would really, but for its continuance, be of little moment. There is one other point of importance in reference to this metrorrhagia; viz., that, except in persons who have previously suffered from dysmenorrhœa, it does not give rise to any pain; on the contrary, the pain which existed previous to the discharge is rather relieved by it; so that it seems to be, as it were, a critical and spontaneous discharge, after which resolution begins.

The improvement just referred to is influenced to some extent by the character of the crisis; for in some the discharge is not sufficiently free to bring much change. It depends also upon the character of the genital affection; scrofulous catarrh, for example, irrespective of the discharge, tends to produce temporary improvement in the peritoneal symptoms. This influence is such, that not only does it tend

* Nonat, *loc. cit.* p. 273, *et* Letellier. *Thèse inaugurale.* Paris, 1858.

to modify the results of the bleeding, but it even affects the bleeding itself; at least, as regards its frequency and amount. It is less frequent in blenorrhagic pelvi-peritonitis, still less in that caused by uterine catarrh and in the traumatic variety; while it is more common in the puerperal, and still more in the menstrual variety. In these two latter it frequently happens that the lochia or menstrual discharge will, for a time, during the more acute inflammatory symptoms, diminish; and, when these subside, then the former become more free again, and last for some time. I ought to mention, however, that in the puerperal pelvi-peritonitis, the character of the metrorrhagia is influenced somewhat by season; thus in the year 1858 it was a very frequent symptom, while in the following year it was rarely met with. This is an important point to bear in mind, when it is remembered that in those two years the proportion of cases of malignant puerperal fever was very dissimilar in comparison; so that we might legitimately attribute the frequency of metrorrhagia in 1858 to the influence of the dominant medical constitution of that day.

Should this coincidence be found to exist in other epidemics, it would make the frequency or rarity of hæmorrhage in puerperal pelvi-peritonitis a matter of some importance. If frequent, we might reasonably dread that a cruel epidemic would soon follow wherever benign puerperal fever which had already shown a hæmorrhagic tendency had appeared; and therefore hygienic measures ought to be taken at once to diminish, if possible, the mortality which decimates the obstetric wards at such times.

This is a question, however, which, interesting and important though it be, is foreign to the subject we are considering; viz., the relation which exists between metrorrhagia and pelvi-peritoneal inflammation. If the peritonitis does *not* occasion hæmorrhage, it at least excites it and makes it freer, especially after abortions; and, under these circumstances, the best hæmostatic we possess is the application of some leeches, or a large blister over that iliac fossa which is the seat of pain; it arrests the hæmorrhage by the good influence which it exercises over the peritoneal inflammation. To conclude my remarks upon this subject, I should say that all the preceding is opposed to the symptomatic value which M. Laugier has attributed to the coincidence of pelvi-peritonitis and metrorrhagia; and negatives the idea that this coincidence is any way pathognomonic of hæmatocele.

I shall not insist further on this point, but I must not omit to mention one very interesting fact; viz., that hæmorrhages, both primary and secondary, which are so frequent at *Lourcine*, are much less so at *La Pitié*.* This difference has led me to enquire whether there are not some endemic causes peculiar to the former hospital which might account for it. No doubt the habits of life of the patients, in the former case, goes for much; for it is a fact that women who live lives of sexual excitement, as the majority of those who come into *Lourcine* do, are subject to metrorrhagia. But I believe that the frequency of this symptom in the *Hôpital Lourcine* is due to causes which may operate equally at any other hospital, viz., to the mercurial treatment to which the majority of these patients are necessarily subjected. I say this, because I have frequently seen excessive metrorrhagia occur in cases where a course of mercury was being administered, whether for a uterine or any other affection. Among other examples, I may mention that of a young girl, 20 years of age, of good constitution up to the time of her admission into the Hospital, where she was received for a chancre of recent date, situate on the left labium, and unaccompanied by any vaginal discharge. In this case, menstruation had hitherto been perfectly regular and normal in quantity; but, fifteen days after an ordinary period, an erythematous redness appeared at the fundus of the vagina and cervix; and, two days after, a free, bloody discharge came on. This hæmorrhage, which came on three weeks after her admission into the Hospital, could not be attributed either to an abortion, or to excitement of the generative organs; or to any affection of the uterus or its appendages, which were healthy; or to any disease of the vagina, which, prior to the erythematous redness, was perfectly normal. Nor did it seem to me due to the syphilitic affection, which was of the simplest possible character, and had not given rise to any constitutional symptoms, nor to the healing of the chancre, which readily yielded to the influence of the proto-iodide of mercury, and opium. This effect of the mercurial in cases where there is no affection of the uterus or its appendages, is increased where there is; and especially when it has been of sufficiently long

* M. Letellier, (*Des métorrhagies symptomatiques, thèse*. Paris, 1858,) has also remarked upon the frequency of metrorrhagia in syphilitic subjects; but, while he attributes it to the syphilis, I believe it due to the mercurial treatment, at least in the early stages of syphilis.

duration to produce that cachectic condition which is common in cases of pelvi-peritonitis.

The metrorrhagia, which occurs under these circumstances, is marked by several characteristics. Thus, though it deserves the name of passive, from its cachectic origin and the serous character of the discharge, still it presents a certain acute appearance which is rare in the early stages of pelvi-peritonitis. The patient experiences a certain malaise, with weight about the pelvis, and more or less marked dysmenorrhæic pains, which are only relieved when there is a free discharge of blood from the uterus. After a while, however, if the discharge continues free, the debility which it occasions rather increases the suffering than otherwise, and the consequent anæmia and cachexia tend to a renewal of the metrorrhagia. Thus the re-establishment of health becomes more and more uncertain.

Progress and Termination.—From all that has been said, we can understand how the duration of pelvi-peritonitis, and the accidents to which it gives rise, may vary from a few weeks to many years. We can understand, too, how different circumstances—the nature of the genital affection which originated the pelvi-peritonitis, the idiosyncrasy of the patient, her social condition in life, and the kind of treatment which has been pursued—modify the progress and termination of the case. Nevertheless, it is rare, as I have several times said, that pelvi-peritonitis causes death, at least directly, though it may give rise to tubercular consumption, if the patient has any tendency thereto. I have already (Case V.) reported an example of this kind, and shall return again to the subject; it has already occurred to my friend and colleague M. Aran* as well as myself. I refer to it here, because I want to establish the difference between the direct and indirect cures of pelvi-peritonitis which sometimes take place. The latter occur more frequently in the chronic forms of the affection—whether it began acutely, or in that slower and more insidious way, which has received the name of latent. It is in the history of these latent forms of pelvi-peritonitis that the descriptions of morbid conversions which I am about to give apply; I shall only consider the regular terminations of the acute form.

The most satisfactory termination rarely happens before three or four weeks from the commencement of the affection, which gradually begins at a catamenial period, no matter what form of pelvi-peritonitis

* Aran, *loc. cit.* p. 717. Siredey, *loc. cit.* p. 48.

it is. This favourable resolution, which is more frequent in menstrual pelvi-peritonitis and in those arising from venereal excess, than in the parturient variety, whether it occurs at full term or prematurely, which is rare in the other varieties, especially if the patients are not in good health, is characterised by a rapid subsidence of the early symptoms. After some bleeding, whether it occurs spontaneously or results from leeching the cervix, a kind of convalescence is established which, unless guarded most rigorously, will assuredly lead to an aggravation of the symptoms, to the no small distress of both patient and doctor. In the same way, the greatest care is necessary in maintaining the recumbent position at the return of the menstrual period, for this is pretty certain to lead to an inflammatory attack, which, however, if well directed, may result favourably for the patient; notwithstanding that rather severe pelvic pains remain, similar to those which occur in the case of recent pleurisy; these pains indicate the formation of adhesions, and are not to be met by any active plan of treatment. At the same time, I would caution against a do-nothing system, for pains of this kind sometimes afford valuable therapeutic indications, though they may be merely of a hygienic character. During the formation of false membranes, the patient returns to her usual health; the leucorrhœal discharge, which had been abundant since the improvement of the symptoms began, now stops: menstruation becomes regular, the general health improves, and the local symptoms disappear.

Unfortunately, however, such complete and rapid improvement very seldom takes place, either because of the severity of the inflammation, or because the progress of the affection is disturbed by other causes arising from the constitution of the patient or from her social condition. Under one or other of these influences, convalescence is or may be for a time retarded; the pelvic pains increase, especially with the return of the period; the discharge, however, generally leads to some improvement, which lasts at least till the following menstruation; when, if after some increase of pain the function is normally performed, a cure may result. The pelvic pains which accompany the cicatrisation of the pelvi-peritonitis last for some time, and the uterine deviation is maintained by the surrounding adhesive bands, thus frequently exposing the patient to a renewal of the symptoms.* Should menstruation not return, or if it returns incompletely, all the

* Gallard, *Thèse*, p. 32. Paris, 1855.

symptoms reappear with probably increased severity, the peri-uterine tumour being notably augmented in size. A delay of one, two, or more months may ensue; the pains will become more persistent; the adhesive bands more firm through the retarded absorption of the inflammatory products; and thus for years, it may be, the patient will remain in imminent danger of a return of the peritonitis.

We cannot, however, trace month by month the progress of this affection, which presents a varying history of improvement and relapses, each case, probably, differing from every other. It is sufficient to remark that the general condition of the patient; the diatheses which may arise to complicate the genital affection; the cachectic condition, favoured probably by the treatment adopted; and lastly, the evil habits of life of some of these patients, all these act as retarding influences in the process of reparation. It is unnecessary for me to remark upon the nervous condition, which is sometimes associated with the pelvi-peritonitis, especially where there have been several remissions and exacerbations; nor need I comment upon the influence which these two conditions exercise one upon the other; for I have already dwelt at some length on this characteristic of the chronic variety of the affection. I shall only add that this is by no means necessarily dependent upon the pelvi-peritonitis; it is an element which ought either to be regarded as connected with the cachexia to which the long duration of the affection gives rise, or as due to the hysterical or hypochondriacal condition which the orchitis has produced, not directly, but through the depressing association constantly connected with affections of the generative organs.

It is worthy of remark that this class of affections more than any other excites in both sexes, but especially in the female, a hypochondriacal condition. That the cause of this condition cannot be located in the uterus is certain; and my principal object in alluding to these nervous phenomena is rather to divert attention from the trifling induration, which has hitherto received a larger share of attention than these more important details. It is far better that this should be quietly absorbed, without having recourse to mechanical measures, many of which are fatally injurious and only lead to a return of the pelvi-peritonitis with other and perhaps greater dangers. I have, for instance, before alluded to the danger of using the sound under these circumstances (Case XVIII.); and the memory of every practitioner will furnish him with

illustrations of the sad effects of attempts to redress the uterus.* Similar results have followed the use of even simpler means, as in the two cases recorded below,† where in one inflammation resulted from the cauterisation of the cervix, in the other from the employment of a caoutchouc pessary.

It is unnecessary to remark upon these two cases; for nothing that I could say would enhance the observations made by M. Aran to whose work I would refer all those who are interested in this question. I will only state that in those cases where there is a return of the acute symptoms, the product is by no means limited to serum or fibrin, but not unfrequently ends in the formation of pus. Hence,

* Discussion at the Academy on the use of intra-uterine pessaries. 1854.

† Case of M. Aran taken from his *Leçons cliniques sur les maladies de l'utérus*. Obs. xvii. p. 667.

A young woman aged 24, was admitted 3rd August, 1857, had her first child at 17, followed by slight peritonitis. While lifting a heavy weight in 1855, she felt something give way, after which she suffered from pains in the back and down the left leg, with dysmenorrhœa. On examination the cervix was prolapsed, elongated, and conical. The body was retroflexed, but could easily be replaced; uterus moveable. By the advice of Professor Faye, of Christiana, M. Aran determined, on the 7th August, to attempt replacement, previous to which the cavity of the cervix was freely cauterised, so as to destroy the sensibility of the mucous membrane. On the 16th, a swelling was discovered towards the left iliac fossa, probably ovarian; tender on pressure; twenty leeches were applied, followed by blisters, etc. For a time she gradually recovered, but died on the 12th of November from capillary bronchitis and pulmonary congestion.

On *post-mortem* examination numerous adhesions were found between the uterus, rectum and bladder. The left ovary was compressed and flattened against the rectum, to which it was adherent. The uterus was completely retroflexed; and, though easily replaced, it immediately returned to its mal-position. There was no other special feature.

In another case of M. Aran, (*loc. cit.* Obs. xi. p. 606.) The patient had for a long time suffered from chronic pelvi-peritonitis, together with chronic pulmonary tubercularisation. In consequence of some contraction of the vagina, gum-elastic pessaries were being introduced; and, in a little while, symptoms of peritonitis came on, which continued increasing till she died, on the morning of the 17th.

On *post-mortem* examination, there was found to be general peritonitis. The uterus was a good deal enlarged, and the cervix ulcerated. The left Fallopian tube was adherent to the left ovary, and dilated into a cyst which, however, contained no pus. Both ovaries were hypertrophied; there were tubercles in the right lung.

as a consequence of this change in the secreted product, the progress and termination of the case varies also, and resembles in this respect purulent pleurisy. The only kind of similarity between the purulent and sero-adhesive forms is where the suppuration is so limited as to give rise to a small abscess, which remains inert amid the surrounding mass of false membranes for a longer or shorter period, according to the circumstances of the case.*

The two cases to which reference was just now made, may be regarded as to some extent exceptional, because the purulent collection in them was of such short duration, that it is impossible to say whether or no diminution might not have taken place. In one case, certainly, there was evidence of such an attempt having been made. In the other, the muco-purulent collection was semi-tubar, and semi-intra-peritoneal, and the fear was that it might give rise to even more severe symptoms, possibly from the influence merely of menstruation, as in the following case, the details of which I owe to M. Almagro.

CASE XIX.—*History of pelvi-peritonitis, giving rise to dysmenorrhœa.—Sub-acute-peritonitis.—Death.—Autopsy.—General*

* Obs. of M. Siredey. *Thèse inaugurale*. Paris, 1860. Obs. xiii. p. 132.

A woman, aged 28, was admitted 10th August, 1859. She had had two children, and after the second an attack of pelvi-peritonitis. On admission she was suffering from anæmia. The uterus was retroflexed, and could not be redressed; an attack of peritonitis followed the employment of the sound, of which she died on the third day.

On *post-mortem* examination there was found to be general acute peritonitis. The fundus uteri was fixed in its mal-position by old adhesion, preventing its re-position. The left ovary was a good deal injected, enlarged, indurated, and ecchymosed. The left Fallopian tube contained some little pus. The tube and ovary of the opposite side were in a somewhat similar condition. The mucous membrane of the uterus was thickened, and a good deal congested.

In another case of M. Siredey, *Thèse inaugurale*, Obs. xiv. p. 135:

The patient, 21 years of age, had suffered a long time from pelvi-peritonitis; the uterus was fixed, the cervix a good deal hypertrophied and indurated—for this she was treated and cured. In May, 1859, she came under observation again for metrorrhagia. The cervix still hypertrophied. The actual cautery was applied, and was followed by an attack of peritonitis; suppuration succeeded, and the matter escaped per rectum. She ultimately made a good recovery.

peritonitis, encysted abscess of the right tube ; perforation ; recent abscess of the left tube ; adhesions between the uterus and the rectum ; serous cyst on the right latero-inferior part of the anterior surface of the uterus ; cellular tissue of the broad ligaments healthy.

M. F., aged 33, admitted into *La Pitié*, February 18th, 1861, has generally enjoyed good health till the beginning of last year. Menstruation began at 15½, with pain and general malaise. Since then she has been regular, the period lasting five days freely, but without clots or pain. She married at 21; two years after she miscarried at the fourth month; six weeks after, the period returned, but she has not been pregnant since.

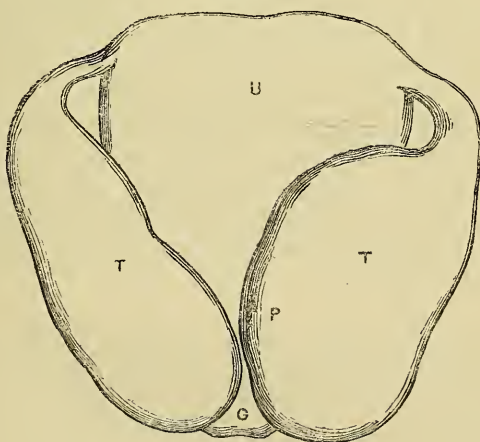
In January, 1861, during menstruation, she was seized suddenly with acute pain in the lumbar region and iliac fossæ, especially the right, accompanied with fever and nausea. She kept her bed for three weeks, but did nothing more than poultice the abdomen. Next month she suffered less pain, but was obliged to remain in bed for a few days.

During the next two or three months she suffered nothing, except at the periods, when the old pain returned, and was always aggravated by going about. On admission she had the appearance of being in great suffering; pulse 100, small, thready. The pain was most severe in the left iliac fossa, and was increased by the slightest pressure. The vagina hot, not tender; the cervix pushed against the pubis, directed from left to right, and somewhat rotated on its axis. In the left cul-de-sac was a soft, boggy tumour, very tender on pressure, non-fluctuating, hot, the vessels pulsating, and the mass extending to the posterior cul-de-sac, which was filled up on its left side. On the right of the posterior cul-de-sac was felt a similar boggy deposit, extending towards the right cul-de-sac, where its outline was lost. The uterus was almost fixed. She was ordered lemonade and seltzer water, gum julep and opium, opiate poultices and rest. On the 19th, she was somewhat better, less pain and tenderness; local signs the same; ordered calomel internally, mercury and belladonna externally.

On the morning of the 20th, she was somewhat relieved; but in the evening she was worse; vomiting and diarrhœa supervened, tympanitis came on, and great tenderness over the lower part of the body, especially on the left side. Some castor-oil was ordered; the vomiting and diarrhœa stopped. She died suddenly four hours after.

Autopsy thirty-five hours after death.—Before opening the abdomen, the cervix was found to be directed to the right, the uterus completely fixed, the anterior cul-de-sac almost obliterated. The left lateral cul-de-sac was smaller than usual, and some bands could be felt stretching across it. The right cul-de-sac was occupied by a hard tumour projecting into the vagina, and extending to the middle of the posterior cul-de-sac; by pressing with the hand on the right iliac fossa, while the index finger of the other hand, introduced into the vagina, pressed upon the right cul-de-sac, the tumour, situated in that part of the pelvis, could be distinctly made out. There was evidence of general peritonitis on opening the abdomen; and, on lifting the intestines out of the pelvis, the uterus and its appendages were found so matted together as to be, at first, indistinguishable. To the right of the uterus a tumour, the size of an egg, resembling an empty bladder, was found. This tumour was formed partly by the right Fallopian tube, which was distended with pus, and partly by a serous cyst. The peritoneum covering the bladder was thick, but the sub-peritoneal cellular tissue was healthy. The same may be said of that covering the anterior part of the uterus and of the broad ligaments. Between the uterus, bladder and right ovary, was a small serous

FIG. 12.



U. Posterior surface of uterus. C. Cervix.
 T. Left Fallopian tube. T. Right Fallo-
 pian tube. P. Perforation of tube.

cyst. On the posterior surface of the uterus (Fig. 12 U) were two

tumours, formed by the Fallopian tubes. Bands of false membrane passed from the posterior surface of the uterus to the sigmoid flexure. The peritoneum, which formed the utero-rectal cul-de-sac, was thick, irregular, and covered with false membranes, which, united by the two distended Fallopian tubes, entirely filled this pouch. The walls of the uterus were red and infiltrated with blood; its internal surface covered with pus; the cervix large, turgid, of a violet colour, but containing no pus in its canal. The two Fallopian tubes were united behind the uterus in the posterior cul-de-sac, leaving the posterior surface of the uterus free, as is seen in the sketch, Fig. 12. By means of some false membranes, they were slightly adherent to the uterus, and to the walls of the cul-de-sac, but not to the rectum. They were covered with fibrinous products; their fimbriated extremities had disappeared. The right was enormously distended three and a-half inches long, and two and a-half in diameter; its internal surface was black, like the choroidal pigment. At the ostium uterinum, the calibre of the tube was normal, but its walls thick. At the other end of the tube was a minute opening, through which, by pressure, the contained pus could be extruded.

The left tube, in like manner, contained a collection of matter; it was nearly three inches long, and one and a-half in diameter; its internal surface was thick, very vascular, and the colour of hepatised lung, permeable at the ostium uterinum. There was no perforation or ulceration at the other extremity. The right ovary was adherent to the uterus, and contained some small serous cysts; its peritoneum was very thick. The left ovary, much smaller than the right, was also united to the uterus by false membrane. It enclosed a clot in a small cavity half-an-inch in diameter. This cavity was lined by a membrane, which was easily detached from the parenchyma of the ovary.

There are two important points to be noted in this case; first, the apparent improvement which took place thirteen months prior to the fatal termination; and, secondly, the marked change in the retro-uterine tumour a few days before death, with the condition observed at the *post-mortem* examination. It is not necessary to compare the anatomical lesions found after death with the symptoms observed during life, in order to trace a connection between them. There is no doubt, that after the menstrual derangement which occurred in

January, 1860, some pelvi-peritonitis was set up from inflammation of the Fallopian tubes, especially of the right. Further, notwithstanding that this inflammation gave rise to an abscess, the acute symptoms of the pelvi-peritonitis improved under the influence of rest and poulticing, but only to lapse into a more chronic state which, from its mere duration, led the patient to believe herself cured. During this sort of spurious cure, menstruation was more prolonged, more abundant, more like a hæmorrhage, and attended by so much pain as clearly to suggest that the menstrual molimen re-excited the intra-pelvic inflammation, but so slightly as to disappear in a few days. Slight as these symptoms were, however, it is right thus to notice them, though they were the only signs of the existence of that purulent collection in the right tube, the perforation of which at a subsequent menstrual period gave rise to the fatal attack of peritonitis. Hence the occurrence of similar phenomena after like improvement ought, notwithstanding their slight symptomatic importance, to justify a very guarded prognosis.

The frequency, in my experience, of these tubar collections of pus in women who appear to be cured of attacks of orchitis, and who have afterwards succumbed, some from intercurrent diseases (Case I.), others from general peritonitis, the result perhaps of cauterisation,* or catheterism (Case in note, p. 97), or simple examination (Case in note, p. 71), or of menstruation, as in the last case; this frequency, I say, makes it necessary to reckon on such a possible contingency after any attack of pelvi-peritonitis. And this is more especially the case where marked functional disturbance of the generative organs exists after an attack of orchitis. It is conceivable, too, that in a certain number of cases, the existence of a similar lesion may account for the pains, whether continued or intermitting, which arise often from very trivial causes. The obscurity of the symptoms of these purulent collections, the absence of any decided symptom in the great majority of cases, keeps one in dread of a relapse of the orchitis, which is so liable to recur; and which, where the abscess is in the Fallopian tube, may end in fatal peritonitis. Hence the fear of the occurrence of inflammatory symptoms, after a long continuance of pain of this kind, should lead us to proscribe all kinds of bold or hazardous treatment which might possibly light up inflammation.

The details of the preceding case prove, undoubtedly, that the

* Aran, *loc. cit.* p. 651.

increase in the retro-uterine swelling was due to an inflammation of this kind induced merely by the menstrual molimen. The perfect integrity of the cellular tissue, which formed a thin ring round the cervix, and that also in the broad ligaments, is conclusive evidence that the retro-uterine tumefaction was not due to any inflammation of that structure. In a word, it proves that there was no peri-uterine phlegmon in this patient, notwithstanding that during life there were the evidences which, according to M. Nonat, are characteristic of phlegmasia of the cellular tissue in those parts; they even existed after death when it was proved that the affection was located in the peritoneum. This case and that of my friend M. Boucher (Case III.), in both of which a fatal result took place very speedily, make it impossible to believe, with M. Nonat,* that any resolution of the inflammation of the peri-uterine cellular tissue took place at the time of death. Hence it is evident, that a tumour having all the signs of a phlegmon, may be simulated by the existence of adhesions between the intra-pelvic organs; and the more so, if there be any considerable purulent distension of the Fallopian tubes.

This point need not, however, be further insisted on, for it is abundantly proved by the cases which have been already detailed. There is one point, however, the interpretation of which is very difficult—viz., the difference felt on examination a short time before death and after it. I must confess that, though I have thought a good deal on the subject, I have not been able to determine why the retro-uterine tumour, which before death was most prominent in the left vaginal postero-lateral cul-de-sac, was, after death, most conspicuous on the right side. It seems scarcely possible that the change in question could be due to any folding back of the right tube caused by the tardy repletion of the left tube, which exhibited all the signs of recent inflammation. Equally unsatisfactory is the notion that it was due, in the earlier days, to the sinking of the right tube, the contents of which were poured into the peritoneal cavity; or to its distension, from partial obliteration of the perforation; or, lastly, from there being some slight inclination of the uterus, together with the two adherent Fallopian tubes, from the products of the peritonitis. This last hypothesis appears to me to have but little foundation, because the inflammation of the serous membrane, instead of resulting in sero-albuminous effusion, such as took place three months previously, ended, on the contrary, in purulent effusion. The character of the effusion in the preceding case seems to show that it was

intermediate, as it were, between the more common sero-adhesive form of pelvi-peritonitis, and the purulent variety, which I am now about to describe.

II.—PURULENT PELVI-PERITONITIS.

THIS form of pelvi-peritonitis (it must be borne in mind that I exclude those cases of malignant puerperal pelvi-peritonitis, which are accompanied sometimes by phlebitis or lymphangitis) is much more frequent after parturition, whether at term or otherwise, than after any other pathological condition which gives rise to orchitis in the female. This difference in regard to frequency, which fully bears out the distinction drawn by Valleix between the puerperal and non-puerperal varieties, is so evident, that I need not dwell upon it; nor is it necessary to remark that suppuration of the pelvi-peritoneum is quite possible in the early stages of the non-puerperal variety,* and indeed in all varieties, as is seen in Case III. in this volume, and in the cases reported by M. Huguier, p. 72; and M. Aran, p. 96 of this volume.

In this form of female orchitis, the symptoms, either from the first, or after a few days, are much more severe than those which occur in the more common sero-adhesive variety. Sometimes the symptoms almost equal in severity those of general abdominal peritonitis (Case III.), but with this difference, that, though the general symptoms may be as severe, the local are not. Thus the tension of the abdominal walls, the spontaneous pain, and sensibility, instead of occupying the whole abdomen, is limited to the hypogastric region; and merely radiates thence to the abdomen and lower extremities. Moreover, there is a great difference in regard to the functional derangements of the pelvic organs in the two cases; constipation, or, on the contrary, diarrhœa and tenesmus, dysuria, symptoms referrible to the uterus and appendages, and especially the production of a peri-uterine tumour, always attract attention.

As regards the tumour itself, there is generally a very marked and peculiar resistance, very like that met with in cases of hæmatocele in its earlier stages, only a little more distinctly fluctuating. This fluctuation, contrary to the opinion of M. Nonat, who denies that these tumours can be soft at first, becomes more and more marked as the other symptoms improve. In the more severe form of the affec-

* Valleix, *Guide du médecin praticien*, t. iv. p. 257. 3^e édition.

tion, the symptoms, in spite of treatment, gradually increase in severity, until general peritonitis sets in as severely almost as if intestinal perforation had taken place. Happily this form of the affection is exceptional, especially in the non-*puerperal* state. At the same time, a good number of cases do occur in the general lying-in-hospitals in the course of a year's service, and they are of a most painfully fatal character. An instance of the kind is referred to below.*

We may, however, hope to cure some of these, though perhaps incompletely; the patient being afterwards subject to hypogastric or lumbo-crural pains on slight exertion; especially in the less severe forms, such as that described by M. Nelaton (Case XXXVII., vol. I.) which may be regarded as typical. In these the inflammation, after a few days, begins to subside; the pain and abdominal sensibility diminishes; at the same time the tumour, instead of acquiring increased consistency, presents, on the contrary, greater elasticity. But, in spite of this amendment, no real progress is made; diarrhœa takes the place of constipation, debility increases rather than otherwise; the skin becomes dirty white; the fever continues; rigors occur every evening, with night sweats, and symptoms of deep-seated abscess. This state lasts with increasing severity for a variable period, during which the peri-uterine tumour gradually increases in size, becomes more tender, more elastic, and at last indistinctly fluctuating. Then, unless it is decided to evacuate the pus by vaginal incision, in the course of a few days or weeks there is a marked aggravation of the symptoms, tending to a natural escape of the pus. At this time the hypogastric pains are increased; the tumour enlarges, becomes more elastic and tender to the touch; leucorrhœa increases; diarrhœa, which perhaps had been replaced by constipation, returns, and assumes a dysenteric character (the *entérite glaireuse* of M. Nonat.)† With these symptoms, there is more or less febrile reaction, indicating the approaching escape of pus into one of the neighbouring organs—an escape which may be considered fortunate, if the opening

* Tarnier, *Thèse inaugurale*. Paris, 1857, p. 63.

M. Tarnier describes this as a case of "*puerperal fever in the non-pregnant*," which ended fatally on the fourth day. On making a *post-mortem* examination, a good deal of purulent serum was found in the peritoneum. The uterus and its appendages were healthy.

Another case of a similar kind is also described; but the patient recovered.

† Nonat, *loc. cit.* p. 373.

is made either into the uterus, or the vagina, the bladder or the intestine; but which, on the contrary, will be rapidly fatal if it escapes into the abdominal peritoneum.

Such is the general opinion as to the mode of escape of the pus; but I must observe, that, though some of these spontaneous openings may have been demonstrated anatomically, it is not the case with all. Thus, the case which M. Vidal (de Cassis) adduced as one of ovarian abscess opening through the uterus, cannot be regarded as proved; and the same applies to the case of M. Marchal (de Calvi) which is reported in his thesis.* The spontaneous opening of these purulent collections into the vagina, though I do not dispute the fact, since they have been frequently opened there,† has nevertheless not been demonstrated, at least to my knowledge, by any autopsy. Lastly, the opening through the bladder has only been demonstrated in one case, which was very briefly reported to the Anatomical Society,‡ in which it was shown that one Fallopian tube, enormously distended with pus, communicated with the bladder, to the posterior wall of which it was adherent. Happily, no doubt exists in regard to the opening into the digestive canal, which occurs more frequently than any other, and also more often ends in cure. It was proved anatomically in the case recorded below,§ that pus escaped into the rectum; and in another case, which I shall report presently, it opened into the cæcum.

I will now describe the different phenomena which are produced when the perforation is situate so as to allow of the easy escape of the pus; and, as in the following case, results in a cure.

* Marchal (de Calvi), *Thèse d'agrégation*, 1844, p. 136.

† Nélaton, *loc. cit.*

‡ *Bulletins de la Société anatomique séance du, 22 Fev. 1861.*

§ Case of Dalmas, *Journal hebdomadaire*, 1828, t. i. p. 114.

M. D., 37 years of age, mother of three children, was admitted into *La Charité*, September 2nd, 1828, with a tumour in the left side, tender to the touch, pain extending down the left leg. Tumour was regarded by M. Andral as degeneration of the ovary; and, as it was thought to be in a state of activity, leeches were repeatedly applied, together with blisters. The pain, however, increased, and became more extensive; and obstinate vomiting and dysenteric diarrhœa, with purulent discharge, supervened, from which she died on the 9th October.

On *post-mortem* examination, there was evidence of extensive peritonitis, the viscera being matted together by adhesions. A tumour was found to the left of the uterus, to which the rectum was adherent; and, on separating

CASE XX.—*Abortion at the second or third month, followed by pelvi-peritonitis, and symptoms of suppuration ; four days after, evacuation of pus per anum ; gradual disappearance of the retro-uterine tumour.—Cure.*

C. D., aged 28, was admitted into *La Pitié*, 19th of January, 1861: had been regular since she was 17. A year ago she became pregnant for the first time, and aborted at the sixth month from excessive fatigue. A month after, when menstruation came on, she experienced pain in the pelvis, for which she consulted a midwife, who advised her to wear a rather tight bandage. Menstruation regular, and without pain ; subsequently she had metrorrhagia, for which she was admitted. On examination the cervix was obliterated, soft, open, and ragged ; the uterus large, as if from recent abortion ; the vaginal culs-de-sac healthy. Ordered an astringent drink, opiate poultices, and soup.

On the 23rd, she was much the same, except that the discharge was greatly less ; four leeches were ordered to the cervix ; these, however, produced but little change.

On the 25th, she was suddenly seized with violent colic, resembling labour pains, most severe in the right iliac fossa. This was followed by rigors, nausea, and vomiting ; examination gave great pain, especially in the posterior cul-de-sac. The vaginal culs-de-sacs were otherwise normal. Ordered seltzer water, a large blister to the hypogastrium, and emollient lavements.

On the 26th, the cervix was found pushed forward and to the left, against the posterior surface of the pubis. The posterior cul-de-sac was occupied by a round tumour, projecting below and behind the cervix ; it was very tender and elastic ; bleeding ceased.

On the 27th she was much the same, distinct fluctuation felt in the tumour, muco-purulent discharge from the vagina.

On the 28th a large quantity of pus came by the bowel ; fluctua-

the two, the latter was found to be perforated. The tumour was composed partly of the ovary, but principally of the Fallopian tube, and was in a state of suppuration. On the right side a similar state of things existed, except that the tumour was formed principally of the ovary. The uterus was healthy. The rectum and part of the large intestine were acutely inflamed ; the former, being greatly compressed by the tumours throughout the large intestine, was much injected, and several ulcerations existed near the ilco-cæcal valve.

tion more distinct in the tumour, as if it were on the point of bursting.

On the 1st of February there was but little improvement; she still passed pus per rectum, and lately more than before; the tumour diminished but slightly; she still had rigors and sweatings alternately. She was ordered generous diet, stimulants, poultices, and emollient lavements.

During the next fortnight she still passed pus, and both the general and local symptoms remained very much as before.

On the 18th it was noted that she was much better, there was less pain, less discharge; the uterus was normally placed; the swelling in both lateral culs-de-sac had disappeared, and that in the posterior cul-de-sac was diminishing.

On the 25th pus no longer passed per anum, and the patient expressed herself as feeling quite well. There was still some pain on pressure in the iliac fossæ; the cervix was in its normal position; the lateral culs-de-sac were normal, the posterior nearly so. A small blister was ordered for the iliac fossæ, to be dressed with morphia.

Early in March menstruation came on, and was unattended by any bad symptoms. From the 20th to the 30th she had metrorrhagia, followed by leucorrhœa. In other respects she was well.

On the 6th of April, she had lost all pain on pressure, both in the iliac fossæ and elsewhere. The left cul-de-sac was very large, the right small; and across it was felt a band, when the uterus was drawn in the opposite direction. In the posterior were felt some small, hard bodies, the size of nuts. She left the Hospital for a convalescent institution, and was not again heard of.

We see in this case, and in two others which I might quote from the very interesting thesis of M. Siredey,* that the severe symptoms, characteristic of the accession of pelvi-peritonitis, improved greatly after the first escape of pus per rectum, then they reappeared during the time when that escape was interrupted; and subsequently ceased when the flow of pus became once more regular. But for nearly a month, during which the pus was slowly discharging, there was continued fever, with occasional rigors, night sweats, complete loss of appetite and increasing debility. This febrile condition, indicative of the suppurative stage, continued as long as pus was being secreted. The

* Siredey, *loc. cit.* Obs iv. p. 105, et. obs. vii. p 111.

diarrhœa, which was symptomatic of a cattarrhal affection of the bowel, and is sometimes a very troublesome affection, ceased with the evacuation of the pus, and convalescence then began. It is unnecessary to point out the characteristics of that convalescence; but I may remark upon the extraordinary varieties of displacements which the uterus underwent. Thus, at first, it was in its normal position, and presented the character of a uterus which had recently aborted; then it became more and more pressed against the pubis as the retro-uterine tumour increased in size; and subsequently, as this was absorbed, the organ returned more to its normal position, but was at last drawn backwards and to the left, by reason of a band of adhesion which existed in that situation.

The stage of convalescence may be variously protracted, according as the discharge of pus continues; or there may be some difficulty in its escape; or the cysts continue to secrete pus longer in one case than in another; or, lastly, the intestinal affection may be more severe one time than another. I shall have occasion to point out that this intestinal mischief sometimes assumes a very serious aspect, and gives rise to other dangerous complications.

Before alluding to this latter question, there are other and more pressing dangers to which these patients are subject, when the curative process follows an irregular course. There is first the danger arising from perforation of the cyst, and the consequent escape of pus through one of the neighbouring organs; the inflammation essential to this process may perchance extend to the abdominal peritoneum. This extension of the inflammation, by simple contiguity from the pelvic to the abdominal peritoneum, is especially liable to occur in cases of puerperal pelvi-peritonitis, at about the end of the second week, when the patient has not taken sufficient care of herself. This happens much more frequently in hospital than in private practice, and especially in those cases where the women insist upon returning to their usual avocations long before they ought. The fact is so well known that I need not dwell upon it; it has been abundantly demonstrated by *post-mortem* examinations.

The remaining symptoms which usually accompany a fatal termination differ but little from those where the opening of the purulent cyst, instead of allowing the pus to escape externally, finds its way into the abdominal cavity; sometimes death occurs instantaneously under these circumstances, as in the case recorded by Dalmas,*

* Dalmas, *reflexions à son observation*, *Journal hebdomadaire*, t. i. p. 117.

and we may recognise the same influence in the case recorded by Pérochaud,* where a psoas abscess burst into the abdominal cavity and speedily destroyed the patient. In some cases the peritonitis runs rather a lingering course, as in the case recorded by M. Boucher.

CASE XXI.†—*Partial peritonitis five days after labour ; hypogastric tumour ; general peritonitis ; death.—Autopsy ; collection of pus between bladder and uterus ; rupture of the sac ; recent adhesions of the abdominal peritoneum.*

A woman, 21 years of age, was admitted into *Hôtel Dieu* in 1841. She had been confined fifteen days previously; and, five days after her labour, she was taken with rigors, fever, and a considerable loss, the milk disappearing; she had pain in the pelvis and abdominal distension.

On admission she was very weak; pulse 130; constipation; no nausea or vomiting. A painful tumour was discovered, occupying the entire right of pelvis; the vagina was hot; the cervix elevated. She was bled, rubbed with mercurial ointment, and was relieved. Four days after, the tumour suddenly disappeared, and symptoms of peritonitis soon supervened, with great pain, fever, and general depression. Twenty-five leeches were ordered to the groins, and afterwards poultices, bath, &c. She died forty-eight hours afterwards.

On making a *post-mortem* examination, there was evidence of general peritonitis; the intestines were matted together. The tumour felt during life was seen to have occupied the entire pelvis; the epiploon was adherent to it; and behind these adhesions there was an oval rupture in the cyst, thus exposing the peritoneal cavity to that of an abscess, pus and flaky lymph was floating about. A little blood existed in the uterine cavity; its walls were thick; the cervix was obliterated; the vagina lax. The cellular tissue round about and in the ovaries was infiltrated with serum. The other organs were œdematous and anæmic.

I would direct special attention to the possibility of this destruction of the false membranes primarily developed, and the dangers consequent thereupon, because the knowledge of this fact will ensure cau-

* Pérochaud, *Bulletins de la Société anatomique*, 1857, p. 205.

† Hipp. Bourdon, *Des tumeurs fluctuantes du petit bassin*, 1841, p. 38.

tion in our estimate of the physical signs of suppurative pelvi-peritonitis. The dread of inducing general peritonitis merely from pressure upon the abdomen, should make us very careful about this mode of examination, for it is quite certain that we may distend and even rupture the adhesions which form the very cyst wall of the purulent collection.

When once suppuration is actually established, very slight causes will often suffice to bring about general peritonitis, and hence the prognosis of these cases should be a very guarded one.

It remains for me to point out the consequences which are likely to ensue when the organism, notwithstanding its efforts to secure the evacuation of the matter, is either unable to effect a perforation, or it takes place in some very disadvantageous position. I must also consider the consequences resulting from the supposed absorption of putrid matter when the opening into the cyst takes place at some depending part. I shall allude first to those symptoms which occur when the opening into the cyst is badly placed, such as happened in the case recorded by Dumas, where the patient died from colliquative phenomena, the opening having taken place into the rectum as much as eight inches from the anus. The following is an example of a similar case which I take from the very interesting thesis of M. Second-Féréol :—

CASE XXII.—*Puerperal peritonitis, sero-adhesive above, purulent and encysted below ; perforation of the cæcum, and escape of pus ; diarrhæa, marasmus ; death ; autopsy.*

An unmarried woman, aged 27, was admitted into *La Pitié*, January 19th, 1859, in labour with her first child, which was born next day naturally.

All went on well for the first few hours, but before the end of the day severe pain was felt in the lower part of the body ; this continued during the next day, but no enlargement of the body could be detected, no great tenderness on pressure, all else seemed to be natural. Mercurial inunction and emollient poultices were applied to the abdomen ; but the pain still continued.

On the 22nd, that is seventy-two hours after the labour, she had a rigor, which was repeated next day ; great fever followed, the lochia were suppressed, and there was much pain, especially in the right

* Second-Féréol, *Thèse inaugurale*. Paris, 1859.

iliac fossa. Next day it was felt in the left iliac fossa also, and was increased by pressure. A large blister was applied to the abdomen. She, however, got worse, with more general distress. Symptoms of hydro-peritonitis came on, and dulness existed on percussion over the abdomen, which varied with the change of position, showing that the fluid was not encysted. She was ordered opium, mercurial and belladonna frictions, and poultices.

Obstinate vomiting came on, which was relieved by strychnia ; but on the 3rd of February she was worse, though the abdomen seemed smaller, and was less painful and tender. The same treatment was continued. In the night of the 3rd and 4th, delirium came on.

On the 7th she seemed to be better, but diarrhœa then began, which reduced her a good deal, and effusion took place into the right pleural cavity. For this a blister was applied, tonics were administered, and the same applications to the abdomen.

On the 18th she was not expected to live the day out.

On the 19th she seemed to have rallied somewhat ; there was less pain ; tenderness and distension of the abdomen ; the chest symptoms also improved ; and in the night a good deal of pus was passed per anum.

During the next four days, as the abdomen diminished in size, an ill-defined swelling appeared in both iliac fossæ, uniting together in the hypogastric region. No more pus passed. The general condition of the patient grew worse rather than otherwise ; she got weaker and more depressed.

On the 5th of March she was evidently worse, delirium came on, with extreme prostration, and she gradually sank and died on the 7th.

Autopsy made the following day. On opening the abdominal cavity, the parietal peritoneum was found to be extensively adherent to the visceral layer, to the epiploon, and to the intestines. These adhesions were firmer and thicker below ; and from one iliac spine to the other the false membranes were so extensive, as to give rise to a kind of induration, which suggested the existence of a tumour. In this region all the viscera were matted together in one hardened mass, below which was a collection of pus surrounding the generative organs. Similar adhesions, though less firm, existed as high as the diaphragm ; in the cæcum three perforating ulcers existed ; but there was no evidence of any escape of fœcal matter from them, until they were torn, in the attempt to separate them from the adjoining parts. On the left side the intestines were firmly united together and to the abdominal

wall; but the descending colon, instead of forming the sigmoid flexure, turned at a right angle towards the sacro-vertebral angle, where it formed another right angle in its descent to the pelvis, and then joined the right border of the uterus. The boundary between the floor of the pelvis with its contained pus and the vagina was extremely thin. The pus was thick, yellow, and offensive; the peritoneum itself had all the appearance of a pyogenic membrane; the uterus was completely anteverted, its cavity contained a black detritus, its sinuses were healthy, and contained no pus; the broad ligaments were thick and indurated. The assistant to whom I entrusted the remaining dissection was unable to complete it. I cannot, therefore, say what was the situation or condition of the Fallopian tubes or ovaries, nor even indeed of the digestive organs.

The point which specially interests us in the case is, the opening of the purulent cyst into the cæcum, and the temporary improvement which followed. At first the peritonitis was very limited in extent; but it subsequently became more general, and then all the digestive organs were matted together. After this, a collection of matter formed in the hypogastric region, in the site of the original mischief, and simulated an intra-abdominal tumour. Here was another difficulty in the diagnosis, and it only proves the necessity of weighing well all the symptoms which occurred in this case, and which may occur in any other. If we carefully study the phenomena which characterised this stage, we shall find that they well established the phenomena of suppuration. The persistence of the febrile condition, the rapid emaciation, the collapse, the intractable vomiting, the localisation of the pains in the hypogastric region, and the extreme resistance which it offered, all these were evidence of the existence of an intra-peritoneal collection of matter, before its escape *per anum*. This opinion would be strengthened if there were added exacerbations and irregular rigors, which did not occur in the case just described. At the same time, it must be remembered, that no one of these symptoms, taken by itself, is pathognomonic of suppurative peritonitis. Nay, more, even when regarded as a whole they are not absolute indications of the existing mischief; for they may occur equally with hæmatocele or tubercular feminine orchitis.

I do not wish to make light of the difficulties of diagnosis; all the patient's antecedents, and the progress of the affection must be carefully studied in order to arrive at a safe conclusion.

I cannot too often reiterate this, for I have seen so many errors in diagnosis in these cases. In some post-puerperal cases, where certain pulmonary symptoms existed, I have known the case mistaken for one of pulmonary phthisis, though all chest symptoms have disappeared on the escape of the pus per rectum.

In the case just detailed, there was no room to doubt that the chest symptoms really did belong to what I have called purulent consumption, following acute peritonitis. There was one question which, for some time, occupied my mind, as death seemed more and more imminent; viz., whether I ought not to plunge a short trocar into the resisting point felt per vaginam in the right iliac fossa, in order to evacuate the matter which the system seemed unable to effect. The condition of the patient seemed to me so desperate, that I should certainly not have hesitated, notwithstanding my great reluctance to resort to anything hazardous, had I been able to discover in the right vaginal cul-de-sac any distinct evidence of fluctuation; I could not, however, detect this, though I made frequent attempts to do so; but, as the result proved, it will not always do to wait till such evidence is indisputable. From the doubt which existed in my mind, the opportunity for action was allowed to pass by; and only when the patient was dying did a part of the matter escape; sufficient, however, to produce a decided, though transient improvement. After a few days, the discharge again became almost imperceptible; and then the diarrhœa, instead of diminishing, became excessive, and the feeble powers of the patient succumbed.

In this case, then, as in that of M. Dalmas, (note, page 105) and in the one detailed below,* the symptoms and the result were just

* Case of M. Cossy, *Mémoires de la Société médicale d'observation*, t. iii. p. 73.

A woman, aged 35, was admitted into the *Hôpital Beaujon*, February 13th, 1843, having aborted, for the third time, at the middle of the third month. After this, she had been almost constantly ailing, with bearing-down pains, &c.; and then, at the end of three weeks, an attack of pelvi-peritonitis came on, accompanied by a good deal of vomiting and diarrhœa. She died on the 9th of March.

On *post-mortem* examination, a tumour was found occupying most of the pelvic cavity, the right side entirely. It was found to be the right ovary in a state of dropsy. There was extensive peritonitis, the intestines being matted together; a large perforation was found in the sigmoid flexure: above, the intestine was a good deal distended and hypertrophied; but there was no ulceration. The spleen, kidneys, bladder, uterus, and left ovary were normal.

those which invariably occur where a collection of matter is unable to effect its escape externally. We shall do well to consider these symptoms for awhile. I have grouped them all under the one title of *purulent consumption*, as I want to show that the various symptoms, which occur whenever the system is endeavouring to rid itself of a purulent collection, bear a very close resemblance to those which are met with in the course of ordinary tubercular consumption. The symptoms in question occur at a variable period after the commencement of the pelvi-peritonitis. Sometimes, as in the case of M. Vieusseux, after some slight improvement in the peritonitis, an unsuccessful attempt is made to eliminate the matter; sometimes, on the contrary, as in the case recorded below,* after a sort of false convalescence, hectic fever comes on insidiously, and a train of symptoms follow. In other cases, as in those two of M. Andral previously reported, and in the one recorded below,† the symptoms of purulent

* Case of Vieusseux, recorded by Delaroché, *Fievre puerperale*, p. 288. Paris, 1783.

A lady, 20 years of age, was delivered, with difficulty, of her first child on the 7th of January, 1780. This was followed by pelvi-peritonitis; and a tumour afterwards appeared, the size of a child's head at the lower part, and to the right of the hypogastrium. She died nine weeks after the delivery.

On *post-mortem* examination the uterus was healthy; an irregularly spherical tumour occupied the right side of the pelvis; it was composed of portions of omentum, of peritoneum, and parts of intestine. In the middle of this tumour was the ovary, enlarged and containing some pus. The rest of the body was healthy.

† Case of M. Aran, *loc. cit.* Obs. xvi. p. 663.

A servant, 38 years of age, was admitted December 19th. Six weeks previously she was delivered of her first child, after a tedious and painful labour. Inflammation set in two days after; but yielded to treatment. Three weeks after, she was taken with pains in the right side. A week after admission, a fluctuating tumour, the size of an egg, appeared in the fourth intercostal space, on the right of the sternum; this broke, and discharged some pus and blood. Double empyema subsequently occurred, and both pleural cavities were evacuated. A fistulous opening into the right cavity remained, and she died on the 1st of January.

On *post-mortem* examination, in addition to the thoracic lesions, there was general peritonitis, adhesion of the intestines to one another, and to the pelvic organs. The recto-vaginal cul-de-sac was full of pus. The uterus was healthy. The right ovary tolerably healthy; the corresponding Fallopian tube filled with pus, and obliterated at its fimbriated extremity. The left ovary contained some pus; the left tube none. The pelvic cellular tissue was a good deal thickened.

consumption come on at the end of a history of chronic pelvi-peritonitis, which has been associated with a series of more or less severe relapses.

The hectic fever which occurs in the course of suppuration impresses the system in a peculiar manner, which is too well known to need any description here. I will only remark, that it is not at all times clearly defined, the irregular rigors, the evening exacerbations, the occasional sweatings, which ordinarily mark the fever of purulent consumption, and gives it its special character, may, as in the case last recorded, (Case XXII.) be found wanting. Where we are unable to demonstrate clearly, by combined internal and external examination, the existence of fluctuation, we must hesitate to affirm the presence of matter, notwithstanding that we may feel, instinctively, as it were, that it is there. This difficulty is far greater in cases of puerperal suppurative pelvi-peritonitis, which is much the most common form, than in any other variety; because, in the early weeks after delivery, the information derived from an internal examination is then indistinct and not easy to interpret, especially where the case has not been watched from the beginning. Under these circumstances, it may surprise some to state, that it is often very difficult to distinguish whether the case be one of purulent consumption, or acute phthisis; the latter being not uncommon after parturition; and, like suppurative pelvi-peritonitis, it is often accompanied by gastric derangements, vomiting, and diarrhœa. Nor is the diagnosis rendered easier by the fact that, on the one hand, the tubercular diathesis is one efficient cause of the chronicity of pelvi-peritonitis, and of its suppurative tendency; while, on the other hand, puerperal orchitis favours the predisposition to phthisis more than a simple accouchement; and, lastly, purulent consumption gives rise to many varied affections, among which disease of the lungs is not uncommon.

The secondary affections which arise in the course of the cachexia, into which persons fall who are striving ineffectually, as it were, to eliminate an intra-pelvic collection of pus, may either attack the parts near to, or remote from the peritoneal cyst. Among the former may be mentioned acute or chronic inflammation of the abdominal peritoneum, the danger of which I have often referred to. I believe that the extension of the peritonitis is more often due to the contiguity of the pelvic abscess than to the purulent consumption itself. Of greater importance is the catarrhal, often ulcerative,

inflammation of the digestive canal, which occurred in most of the cases I have reported. This, probably, as much as any symptom, will, by its gravity, determine the question whether any surgical interference ought to be resorted to. It is not necessary that I should describe the kind of diarrhœa to which I allude, for its distinctive features are too well known; and that it cannot be attributed merely to the contiguity of the bowel to the pelvic abscess is, I think, clearly proved by the fact, that the ulceration is equally diffused throughout the entire intestinal tract; and is, therefore, far removed from the pelvic mischief—moreover, the diarrhœa is precisely the same as occurs in other forms of purulent consumption, no matter where the abscess is situate. It is, however, necessary to guard against the possibility of certain errors in diagnosis; for instance, there is a kind of dysentery which occurs sometimes in the acute stages of the sero-adhesive form of pelvi-peritonitis with which this may be confounded. Then, again, it must be distinguished from that intestinal flux which arises from tubercular or other forms of ulcerative enteritis, and which sometimes gives rise to intra-pelvic collections of matter, either by setting up partial peritonitis, or by leading to intestinal perforation.

Generally about the time when this symptom sets in, other secondary affections arise, to which M. Andral has directed special attention.* These secondary affections may, as in the case recorded below,† attack one or more abdominal or thoracic organs.

The secondary pulmonary affections, which are, for some reason or

* Andral, *Clinique médicale*, t. ii. p. 688, 4^e edition. Paris, 1839.

† Case of M. Sirédey, *loc. cit.* Obs. ix. p. 118, et Aran, *loc. cit.*, obs. xiii. p. 642.

L. J., aged 25, was admitted into the *Hôpital St. Antoine*, July 26th. Had never been pregnant. For a year previously, menstruation had become scanty; she had lost health and strength, and had suffered a good deal of pain in and about the pelvis and legs. A fortnight ago these had become greatly aggravated after her menstrual period. On admission the uterus was depressed and pushed to the left by a swelling on its right side. Three weeks after this, she had symptoms of pyæmia, with obstinate vomiting and diarrhœa, and she died on the 18th.

On *post-mortem* examination there was found a good deal of purulent serum in the left pleura. The viscera of the pelvis were adherent to one another; the uterus anteflexed; the ovaries and Fallopian tubes were adherent to one another, the latter being distended with pus. The uterus was enlarged, and its tissue pale.

other, much more frequent than any other, generally take the character of a sort of broncho-pneumonia, *pneumonia notha*, either with or without attacking the pleura. Hence the symptoms differ from those which belong to purulent consumption; sometimes they are so insidious as scarcely to be noticeable; at other times they clearly indicate incipient pneumonia* while, in others, the signs of pleurisy predominate, so as to mask those of the pulmonary affection. I lay some stress upon these different peculiarities, because the pulmonary affections of which I am speaking, may arise at a time when the patient is by no means *in extremis*; and when, therefore, it may be quite possible, either by the spontaneous or artificial evacuation of the pus, to save her.

It should be borne in mind, too, that these affections are not to be regarded in any other light than as secondary; and they ought not to lead us away from the main point, any more than the secondary affections which arise in the course of tubercular phthisis should make us forget the one primary disease. In short, the various symptoms, and so-called complications, whatever they may be, which arise in the course of this affection, constitute the disease which I have called *purulent consumption*, inasmuch as they all spring out of the attempt and probable failure on the part of the system to get rid of the pus which has been formed.

The important point to remember is, that the intractable vomiting, the kind of dysenteric (not purulent) diarrhœa, and the pulmonary crepitation, ought all to be associated with the rapid emaciation, the peculiar facial expression, and the character of the febrile reaction. This more or less complete group of symptoms may, in fact, serve to distinguish suppurative pelvi-peritonitis from the sero-adhesive form of feminine orchitis, the prognosis of which differs very widely. Of course, the nature and severity of these secondary affections should always be taken into account in estimating the prognosis of any particular case; not only because the very existence of these affections indicates an advanced stage of purulent consumption, but because, also, some of them may even lead to a fatal result before the patient has reached what may be called the cachectic stage; and also because they diminish the chances of success arising from any surgical interference.

When the matter has been let out, either spontaneously or artifi-

* Obs. de M. Andral. Obs. x.

cially, there is the further risk of what is called the absorption of pus, or rather of the elements of pus altered by contact with atmospheric air. Sometimes we get a return of the acute inflammation of the cyst, and an extension of the peritonitis to the abdominal peritoneum, ending rapidly in death. We may also get—though I think it is doubtful in cases of suppurative feminine orchitis, other phenomena which are attributed to the absorption of putrid matter; but I know of no case of suppurative pelvi-peritonitis in which this has happened. I do not deny the possibility of such an occurrence; I only affirm that I have never seen it, nor have I met with it in any of the cases I have collected.

In the early part of this year, I met with an example of pelvic abscess which, after discharging *per anum* for three months, got well. It came on so insidiously, that my colleague, M. Aran, was unable to discover, in the several examinations he made, the existence of any peri-uterine tumour. I have not recorded this very interesting case, because the patient, who, on admission into *La Pitié*, had a peri-uterine left latero-posterior swelling, gave a false address, stating, also, that she was married, which was not the case; and, moreover, declared that she did not know any cause for the mischief. It is unnecessary, I think, to separate these cases of obscure pelvic abscess from other forms of suppurative pelvi-peritonitis, because I am satisfied that their obscurity is due much more to the want of information derived from the patient, than from any actual obscurity in the early symptoms of the affection. This remark applies not more to these cases, than to a large number of those chronic cases of sero-adhesive pelvi-peritonitis, which I am now about to describe:—

III.—CHRONIC PELVI-PERITONITIS.

Pelvi-peritonitis may assume the chronic form, either after having, for a certain time, run a more or less acute course; or, after a relapse, the disease having, up to that time, run a normal course; or it may, from the outset, have assumed a latent form. Its chronic character, especially under the last-named circumstances, depends upon the nature of the genital affection, which, as it were, re-acts upon the peritoneum, or upon the congenital or acquired constitution of the patient.

I need not dwell at any length upon the first of these varieties; because, in pointing out the symptoms, and probable progress of acute sero-adhesive pelvi-peritonitis, I have described the period

when the disease was likely to assume a chronic form. I may observe, however, that, in these cases, the group of symptoms, to which M. Nonat has given the name of *peri-uterine phlegmon*, and which I call *pelvi-peritonitis*, do not all equally present a chronic character; consequently, M. Gallard* is able to deny that sub-acute phlegmons ought to be regarded in this way. One only of the elements of the affection is really chronic, viz., the uterine, the tubal, or the ovarian affection which originated the peritonitis; and which, with each aggravation of the malady, sets up fresh peritoneal mischief, thereby modifying the condition of the peri-uterine swelling.

As regards the chronic character of the genital affection, which originated the peritonitis, and governs the symptoms of feminine orchitis—that depends upon the nature of the affection, and the constitutional condition of the patient. For instance, we may get pelvi-peritonitis as a result of that form of engorgement and enlargement of the uterus which comes on after frequent parturition. More often, however, it depends upon the congenital or acquired constitution of the patient, which either originates the inflammation, or else impresses upon it its peculiar character. Thus, in a great many cases, a cachectic condition will favour a chronic character. And, again, as M. Aran has defined it, “*at least two-thirds of the women who suffer from the disease in a chronic form, are the subjects of tuberculosis.*”†

This statement is, perhaps, somewhat exaggerated; it, of course, includes all forms of chronic pelvi-peritonitis, and also tubercular feminine orchitis, of which M. Aran has met with so many cases that one is surprised he has not given any special description of it, seeing that it is a perfectly distinct affection from simple chronic peri-uterine inflammation. I, therefore, feel called upon to supply this omission; but before doing so, I shall point out the phenomena which mark the early stages of pelvi-peritonitis. Great interest attaches to the consideration of tubercular feminine orchitis; because, in any case of chronic pelvi-peritonitis, one of the first questions to determine is, whether or not it belongs to this variety. Like other cases of tubercular peritonitis, they are generally of slow progress, up to the time when they compel the patient to take to her bed; and they either set in at once severely, or they are slowly developed out of some pre-existing attack of acute pelvi-peritonitis.

* Gallard, *Thèse inaugurale*. Paris, 1855, p. 10.

† Aran, *Leçons cliniques sur les maladies de l'utérus*, p. 716.

Perhaps, the first symptom which the patient experiences is, that after some slight cause a good deal of pain comes on. This is followed, either the same day, or soon after, by a feeling of malaise, loss of appetite, rigors, and slight leucorrhœal discharge. This state of things continues for a variable period; in Case XVIII. it lasted for twelve days, without there being any evidence of peritoneal tumefaction; and when this is apparent, it is so indistinct, that unless one is an adept at this kind of exploration, it is very likely to escape detection. After a time, perhaps after some unusual fatigue, or after sexual intercourse, or after the succeeding menstrual period, the pain increases, and is accompanied by some bloody discharge, or by a more than usually free menstruation, and is followed by some leucorrhœa. These symptoms may, or may not, be sufficiently severe to render the performance of the patient's ordinary duties impossible; at any rate, they continue to increase in severity. Then a tumefaction is to be felt in one of the vaginal culs-de-sac, firm in consistence, surrounding the uterus it may be, and projecting into one of the iliac fossæ. Henceforward, the symptoms are the same as those of the chronic stage of pelvi-peritonitis, which has succeeded to an acute attack, gradually decreasing, perhaps, in severity, with occasional exacerbations, according as the patient is the subject of any cachectic or scrofulous diathesis.

The difference between this variety, and the symptoms of acute sero-adhesive pelvi-peritonitis has reference chiefly to the mode of attack, and extension of the inflammation. In acute orchitis, the symptoms of peritonitis are among the first to be manifest; while, in the form of relapse just considered, the peritoneal symptoms are slowly developed, and are some time before they completely appear.

This difference seems to suggest the idea that the genital affection which reacts on the peritoneum, affects that membrane all the more when it has not been previously inflamed, and is not encrusted, as it were, with false membranes, dividing it into separate compartments or cavities of various sizes. Probably it is owing to this shutting off of the pelvic cavity by previous inflammation, that the early peritoneal symptoms, in the majority of cases of relapse of sero-adhesive feminine orchitis are so little marked; the mischief being thus limited to a very small part of the pelvis. It may be that the consecutive inflammation of these various artificial cavities, is the reason why the disease assumes so chronic a form; while each fresh attack,

each fresh spot selected, is all the while being acutely inflamed. This appearance is all the more real; because, after each separate little cavity has been invaded, the morbid action, involving both the serous and false membranes will, as is always the case in inflammation of cicatricial tissue, be more disposed to relapses on slight causes.

But this anatomical reason for the apparently chronic character of the affection, irrespective of any tendency thereto arising from constitutional causes, does not hold good in those cases of pelvi-peritonitis which are from the outset chronic. This variety, of which Case XII. may be taken as an example, I have seen arise merely from menstrual derangement, in young women who are much enfeebled by syphilitic taint, and by a long course of mercurial treatment. It occurs more frequently in the puerperal state, as has been more particularly noticed by Dr. Fleetwood Churchill, in his memoir on inflammation of the broad ligaments,* which was published between the time of M. Bourdon's work (1841), and the researches of M. Nonat.† Dr. Churchill remarks, "In some cases, after delivery, with or without any preliminary symptoms, the patient experiences a sort of discomfort in one of the iliac regions, not amounting to actual pain; and, on placing the hand on the abdomen, a swelling can be felt. In other cases, after a favourable convalescence, a slight febrile attack supervenes, accompanied by shooting pains in the abdomen. These pass off after a time, but the feverishness continues."

This last group of symptoms, which generally is more marked than is stated by Dr. Churchill, characterises the development of certain phlegmons of the iliac fossæ in puerperal cases, and forms the most common mode of attack in latent puerperal orchitis. After a perfectly natural labour, and without any particular indisposition, the patient on getting up experiences pains in the lower part of the body which exertion increases, and which are accompanied by a feeling of languor; all these symptoms are aggravated by the return of menstruation. In some cases, however, the symptoms seem to improve when menstruation comes on, provided that it be not in excess. On examination it will be found that the uterus is higher in the

* Fleetwood Churchill. *Dublin Journal of Medicine*, 1844, vol. xxiv. p. 1.

† Joseph Boyer, *Thèse inaugurale*. Paris, 1848.

pelvis and larger; its cervix shortened, eroded, and tender to the touch, while, in one or other cul-de-sac, there is an indistinct feeling of resistance on deep pressure, a sort of ill-defined boggy feeling, which gradually becomes more and more distinctly marked. With rest and care, some of these cases recover; while others, especially those of bad constitution, linger on, complaining of hypogastric pains, which are aggravated by any functional or mechanical disturbance, till at last the system is so far enfeebled by continued suffering that it gradually gives way.

Even supposing the patient recovers, she is ever liable to renewed attacks; and occasionally other disastrous results follow, as in the case recorded below;* I refer to the difficulties which arise from peritoneal adhesions in reference to the functions of the intestines, which, as I have seen in *post-mortem* examinations, are sometimes so curiously contorted and bound up by false membranes, that their calibre is reduced to the size of a quill. In these cases, there is such obstinate constipation, that for months or even years no relief is obtained, except by enemas. In extreme cases, injections even cannot make their way; and a kind of intestinal engorgement takes place, to which my former colleague, M. Cossy, has directed special attention. The symptoms arising from this state of things differ from those due to internal strangulation, by their chronic character; and from the fact that a purgative generally relieves, though it may be that a fatal result follows. In certain very exceptional cases, we meet with what M. Nonat has pointed out as symptoms of true strangulation, with aggravated colic. One such case I saw in the *Hôpital St. Antoine*.

It was the case of a prostitute who, three years before, had had an attack of pelvi-peritonitis, for which she was treated by M.

* Case of M. Cossy, *Mémoire sur une cause peu connue d'engouement interne de l'intestin*. Obs. vi. p. 92. *Mémoires de la Société d'observation*. 1856.

A laundress, aged 56, was admitted into the *Hôpital Beaujon*, February 24th, 1845. A fortnight before, she was taken with stoppage in the bowels, which continued up to the time of admission; the bowel was distended, tender, and painful. Purgatives and injections of all kinds were resorted to, but without avail, and she died on the 28th.

On *post-mortem* examination, it was discovered that there was enormous distension of the larger bowel, and an obstruction just where the rectum begins: that this was caused by an adhesion between the rectum and fundus uteri, where was a good deal of false membrane.

Fouquier, since when she had, at different times, been under the care of M. Piedagnel for attacks of colic. When I first saw her in the evening, she was unable to tell me anything of her previous history; she screamed with pain; the abdomen was greatly distended, painful to the touch, and covered with marks of previous leechings. I repeated the leeching; and next day, to my surprise, M. Piedagnel laughed at this, and ordered two drops of croton oil, which by its free action on the bowel, gave immediate relief. This taught me something; and afterwards, in the year 1844, this same patient had two attacks, for which I did *not* apply any leeches. I regret that I do not know what became of this person, whether or no she finally succumbed to the frequent attacks of colic, which became more and more severe; the pain usually began in the left iliac fossa, where the peritonitis, *a venere immoderata*, was of greatest intensity.

The adhesions resulting from pelvi-peritonitis may lead to derangement of the generative functions as well, producing more or less persistent sterility from displacement of the cervix, Fallopian tube, or ovary. In some cases, however, I have seen impregnation follow, even before the feminine orchitis itself was cured. Under such circumstances, one naturally fears that pregnancy will not run on to full time, and that perhaps a fatal abortion may result. I do not, however, share in this opinion, notwithstanding the authority of Madame Boivin, who declares that peritoneal adhesions are the most frequent cause of premature labour. The cases quoted by her fall far short of being conclusive, and are moreover too few in number. I do not dispute that an abortion or even menstruation may light up fresh inflammation, and may end fatally, as happened in the case recorded below,* but this is a very rare termination. Far more frequently we shall find that good rather than harm results from pregnancy. The first month probably may be painful; the third and fourth still more so; the hypogastric pains being often so severe as to compel the patient to take to her bed, sometimes there is superadded to all this

* Case of Madame Boivin, *loc. cit.* Obs. iii. p. 13.

Madame L., age 24, came under notice on the 5th of April. Had had one miscarriage at the third month, which was followed by pains in and about the pelvis and legs. On examination, the uterus was normal in every respect, but immoveably fixed. She died suddenly on the 18th, twenty-two days after her abortion.

On *post-mortem* examination, there were found old peritoneal adhesions; the intestines, especially about the pelvis, being matted together.

obstinate and intractable vomiting. But as soon as the uterus begins to rise up out of the pelvis, these symptoms gradually cease. The labour itself will probably be unaffected by all this, especially if pregnancy has existed previous to the pelvi-peritonitis coming on. In like manner, convalescence after the delivery proceeds normally, except in those cases where perchance pain in one or other iliac fossa raises the suspicion of fresh inflammation being set up; perfect rest and quiet, however, are generally sufficient to put an end to all this.

Occasionally this pelvi-peritonitis leads to the development of pulmonary tubercle, not that the genital affection can be regarded as in any sense a cause of this, except indirectly, where the predisposition exists. In cases of orchitis, the long continuance of the disease, the pain, the necessary confinement to the house, and the active treatment required, all this soon brings on a sort of cachectic condition, which leads to the development of tuberculosis. I do not, however, agree with M. Aran * in the opinion that uterine diseases have any special tendency to develop the tubercular diathesis; nor does the fact of the occasional agreement between the severity of the two affections incline me to a contrary belief. The coincidence in question mostly occurs in those cases where, after menstruation has been suspended, apparently by the progress of the tubercular mischief, it reappears; and that with a renewal of the primary inflammation. When menstruation ceases, not only do the hypogastric pains diminish, but even the peri-uterine swelling grows less and less.

The fact that phthisis may occur as a sequela of pelvi-peritonitis in those predisposed thereto, should make us very guarded in giving a prognosis in all cases of orchitis, and ought also to suggest caution in the treatment adopted, so as to avoid all lowering remedies as far as possible. The case quoted below † shows that we may get tubercle in other places beside the lungs.

* Aran, *Thèse de Siredey*, p. 48.

† Case of M. Aran, *loc. cit.* Obs. xv. p. 660.

A woman, 31 years of age, was admitted into the *Hôpital St. Antoine*, October 29th, 1857. Had had a good many abortions, and one child, after which she had an attack of inflammation; she never quite recovered this, but lost flesh, and strength, and colour. The abdomen alone increased in size, and was tender, and a swelling appeared in the right iliac fossa. The uterus was completely anteverted, and pushed to the right by a tumour irregular in shape, hard, nodular, situate on the left side. She gradually sank, and died on the 15th of December.

On *post-mortem* examination, the liver was enormously increased in size.

IV.—TUBERCULAR PELVI-PERITONITIS.

By the term tubercular pelvi-peritonitis, I understand an affection in women which is analogous to tubercular orchitis in the male. It is somewhat surprising that this disease, which is far more common than is generally supposed, is not described in any of the modern treatises on gynecology. Tubercles may be deposited in any internal genital organ; sometimes only the ovaries are affected; and, according to M. Louis, at least one-twentieth of phthisical persons are thus affected. In some cases the Fallopian tubes alone are diseased, as in the case mentioned below;* and, though the contrary opinion is generally entertained, I believe that the oviducts are more frequently affected than the ovaries themselves; and that, whenever the uterus is tubercular, the oviducts are sure to be so; this, too, notwithstanding the case recorded in M. Louis' work.† I may add, in reference to this question, that when the uterus is infiltrated with tubercle, not only do the tubes exhibit a similar lesion, but they show it in a more marked manner, as in the two cases recorded below.‡ It appears probable,

The intestines were united together, and all the pelvic viscera were one confused mass; so that, except the uterus, which was normal, the rest could hardly be distinguished. The pelvic cellular tissue, especially about the junction of the vagina and uterus, was very much thickened and indurated.

* Case of M. Siredey, *loc. cit.* obs. xi. p. 123.

L. B., aged 26, was admitted into the *Hôpital St. Antoine*, May the 23rd, 1859. After her first labour, she had an attack of pelvi-peritonitis, and a tumour formed on the left elbow; her second labour was very tedious and painful, and was followed by a good deal of pain about the pelvis and hypogastrium. Symptoms of pulmonary phthisis also began to show themselves. After this she had metrorrhagia; and was again admitted into the hospital, when a peri-uterine tumour was discovered. Soon after this, an attack of acute peritonitis came on, and she died.

On *post-mortem* examination, there were found a good many old adhesions about the abdominal and pelvic viscera; the Fallopian tubes were affected with tubercle, and the intestines showed tubercular ulceration. No tubercles could be found in the lungs. The tumours, felt during life, were caused by the enlargement of the Fallopian tubes with tubercular deposits. The left ovary was atrophied; the right enlarged. No pus was anywhere discovered, though there was a good deal of serous effusion and flaky lymph, with adhesions everywhere.

† *Loc. cit.* 1st edition, p. 401.

‡ Case of M. Siredey, *loc. cit.* obs. vi. p. 110.

O. H., age 36, was admitted into the *Hôpital St. Antoine*, May 24th,

therefore, to me, that the uterus is affected subsequently to the Fallopian tubes. In some cases, we find that all the internal genital organs are affected in this way. Such was the case in the patient whose history is given below.* This point is, however, comparatively speaking, of little importance; and it is singular that, however much the genital organs may be affected, they do not give rise to any symptom during life, unless there is also pelvi-peritonitis. Pain is a constant symptom, and to this are added the ordinary symptoms of inflammatory action.

I have already pointed out the desirability of studying the circumstances which precede or follow the onset of the pelvi-peritonitis, because tubercularisation of the genital organs comprehends two distinct orders of facts which, during life, present so little similarity, that they do not seem to belong to the same affection. In the one it comes on slowly as a diathetic manifestation, accompanied by sym-

1858. At the conclusion of her eighth labour she had suffered a good deal from pains in the pelvic and lumbar regions, and was troubled with leucorrhœa. These symptoms became much aggravated after a few months, and she was constantly in a state of fever; was also troubled a good deal with diarrhœa. For all this, she was again admitted into the hospital, when a peri-uterine tumour was discovered; she was at the same time suffering from pulmonary phthisis. She died June 28th, 1858; and, on *post-mortem* examination, the Fallopian tubes were found to be the seat of tubercular infiltration, with considerable distension, and there were numerous adhesions between the various pelvic organs.

Case of M. Reynaud, *De l'affection tuberculeuse de l'uterus*. Obs. i. (*Arch. gén. de méd.* 1^{re} série, t. xxvi. p. 487.)

V. D., aged 39, was admitted into *La Pitié*, suffering from chronic pleurisy. She remained in the hospital three months, and left much relieved. She was re-admitted on May the 3rd, 1830, with severe pain in the head, which proved to be an attack of tubercular meningitis, of which she died on the 8th of May.

On *post-mortem* examination there was found effusion into the cerebral ventricles and tubercles of the pia mater. Tubercles also existed both in the uterus and Fallopian tubes. The ovaries contained several serous cysts. The peritoneum of the uterus and mesentery was studded with tubercular granulations, and the intestine was the seat of tubercular ulceration. The thoracic organs were similarly affected.

* Case of M. Reynaud, *loc. cit.* obs. ii. p. 499.

J. B., aged 45, was admitted into *La Pitié*, May the 11th, 1830, suffering from pulmonary phthisis, of which she died on the 19th of June.

The *post-mortem* examination revealed extensive tubercenolosis; the uterus, Fallopian tubes, and ovaries being extensively diseased.

ptoms of pulmonary phthisis; the genital affection being almost unperceived till the *post-mortem* examination reveals it (Case V.). In the other, on the contrary, the genital tubercles are an early manifestation of the general disease; they are either developed simultaneously in the lungs (Case VI.), or they precede it, or they run their course without any thoracic complication. Hence, those cases in which tubercles are developed in the genital organs as a primary affection, may fairly be termed cases of genital phthisis.

The first of the two classes of cases just mentioned, I shall not stay now to consider, because, though interesting as regards the general history of phthisis, they do not concern the subject I am considering. It is otherwise, however, in regard to the other class, which, with all its varieties, is of great importance in gynecology. Especially is this the case with reference to the premonitory symptoms, the diagnosis of which, though so difficult is, at the same time very necessary, in order to avoid submitting the patient to an active plan of treatment, which would too surely precipitate a fatal issue. There are two distinct kinds of premonitory symptoms; in the one there is no apparent determining cause; while, in the other, they come on during the course of an attack of pelvi-peritonitis, puerperal, blenorrhagic, etc.

The onset of the first variety is often more or less latent; and so far, unfortunately, resembles simple chronic orchitis. Such was the case in the following history, for which I am indebted to my colleague, M. Boucher, who was fortunate enough to diagnose the case correctly several months before death.

CASE XXIII.—*Hypogastric pains and abdominal distension following menstruation; repetition of the phenomena, and admission into the Hospital; tumour occupying the right iliac fossa; pulmonary tubercle; simultaneous progress of the lung and pelvic mischief. Death. Autopsy; tubercle in the Fallopian tubes; pelvi-peritonitis; pulmonary cavities.*

C. G., aged 21, admitted into the *Hôpital St. Antoine*, November 30th, 1860. She had been confined six months previously; four months afterwards she began to complain of abdominal pain, with considerable distension a few days after menstruation. Similar symptoms occurred with increasing intensity on three successive periods. At the third attack, the distension disappeared; but the pain was most severe, especially in the right iliac fossa, where a hard, painful

tumour was discovered, parallel with the Fallopian ligaments. The uterus was slightly displaced, movable and painful; the anterior and left culs-de-sac were free; the posterior contained the retroflexed fundus uteri; the right, a large nodular tumour connected apparently with the right iliac fossa; respiration was harsh under both clavicles.

During the month of December, the tumour increased in size; menstruation became irregular, and symptoms of pulmonary tubercle were developed.

Observing that the two affections proceeded, *pari passu*, M. Boucher diagnosed tubercular ovaritis. The patient gradually got worse, and died on the 10th of April, 1861.

Autopsy.—Tubercular excavations existed in both lungs. The parietal and visceral peritoneum was studded with miliary tubercle, which was more extensively developed in the lower part. The vesico-uterine peritoneal cul-de-sac had disappeared, owing to the existence of extensive plastic deposits; the uterus was healthy; the Fallopian tubes were so extensively studded with tubercular matter, as to give them a nodular appearance; the fimbriated extremities were the same, forming bosses the size of a pigeon's egg. One of these was felt during life in the right vaginal cul-de-sac, and led M. Boucher to diagnose tubercular ovaritis. The ovaries were both apoplectic; there were extensive adhesions in the pelvic peritoneum.

This case may be regarded as fairly representing tubercular feminine orchitis, and the course which that affection usually takes. The first symptoms came on at a menstrual period without any premonition, and gradually increased in severity, without there being any pulmonary symptoms. Further, notwithstanding that phthisis already existed, menstruation, or rather metrorrhagia, went on.

In the case which follows, the attack began quite differently to the preceding; for, instead of beginning like an ordinary attack of pelvi-peritonitis, the early symptoms were those rather of latent purulent feminine orchitis. The peculiar character of the affection was not apparent till later.

CASE XXIV.—*Acute pelvi-peritonitis; enormous abdominal tumour; rupture into the rectum; symptoms of dysenteric enteritis; chronic tubercular diarrhœa; death; large intra-pelvic purulent collec-*

* Aran, *loc. cit.* p. 710.

tion ; destruction of the right ovary and Fallopian tube ; tubercular infiltration of the uterine mucous membrane ; tubercles in the lungs and lymphatic glands.

A young woman, aged 22, was admitted into *La Pitié*, April 24th, 1858. On examination, there was much enlargement at the lower part of the body, especially at the right side, caused by the presence of a globular resisting tumour ; considerable tenderness existed in both iliac fossæ. As the patient was a virgin, there was great difficulty in the examination ; the cervix was carried far back, and the fundus was fixed anteriorly by the tumour. By the rectum, the uterus was felt to be immoveable ; and by combining internal and external examination, fluctuation was indistinctly felt. The uterus was felt to be separate from the tumour. The patient had not enjoyed good health for some time, and was in a weak anæmic condition. The present illness began on the 15th of April, with violent cramps in the stomach, and nausea ; and, on the 18th, leeches were applied to the labiæ, which gave great relief. The pains, however, returned on the 20th ; and, on the following day, a tumour was recognised in the lower part of the body on the right side ; it increased rapidly in size, and she was admitted into the Hospital in a state of great suffering, for which laudanum poultices were applied and opium given.

On the 25th, thirty leeches were applied to the right iliac fossa, and opium was given and applied ; this gave immediate relief to all her symptoms, and produced a sensible diminution of the tumour. On the day following, twenty-five leeches were applied, and some croton oil was administered.

On the 27th, mercurial treatment was commenced.

In the evening of the 28th, while at the water-closet, a large quantity of pus and false membrane was expelled ; and, during the night, the bowels were almost constantly acting, which reduced her to extreme weakness by next day. The tumour then had almost entirely disappeared.

On the 30th, the diarrhœa continued, matter still passing ; the extremities were cold. She was ordered bismuth and opium, which checked the diarrhœa.

On the 4th of May, the uterus was found to be both anteflexed and anteverted ; the vagina and skin were both hot. A blister was applied to the right iliac fossa ; tenderness and diarrhœa, with purulent evacuations, came on, which greatly reduced the patient's strength.

From July to September she continued in much the same state, improving slightly; but symptoms of pulmonary tuberculosis began to show themselves. The uterus became absolutely immoveable; and there was evidence of peri-uterine inflammation. Tonics and analeptics were given for the chloro-anæmia, cod liver oil, pyrophosphate of iron and quinine, were administered. Under this treatment she so far recovered that she could leave the Hospital in the beginning of January. But, unfortunately this improvement was only temporary, diarrhœa again came on, and she gradually sank and died on the 31st of May.

Autopsy.—The abdominal cavity was free from adhesions, except a few between the epiploon and the mass which filled the true pelvis, the sigmoid flexure was also adherent to the uterus and its appendages. On opening the sigmoid flexure a large ulcer was discovered, which opened into a cavity the size of a turkey's egg in the adjoining cellular tissue, and in which was some stercoraceous matter. The tube and ovary seemed to be involved in this; the uterus was lengthened and flattened by compression, and inclined to the left side. The right vaginal cul-de-sac was almost obliterated, the left enlarged. The cervix was small, ulcerated on the anterior lip. The *allongement* of the uterus involved the body chiefly, the lining membrane of which was thickened with tubercular matter, as were also the cellular tissue and pelvic ganglia. The intestine, bladder, and urethra were deeply congested; the former ulcerated; the liver fatty; the lungs tubercular.

The point of greatest interest in this case is, as I have said, the occurrence of pelvi-peritonitis, which was the first indication of the existence of tubercles in the generative organs, though they had no doubt existed there for some considerable period, giving rise to no other symptom than a rather abundant leucorrhœal discharge. It is further to be noted that the inflammation came on without any apparent cause; and was, so far, unlike the generality of these cases. Moreover, the attack was so insidious in its origin, that the day after it began, the patient was about as usual. Generally, the disease occasions some very obscure pains; then, perhaps, on about the fifth day, a swelling appears. On the seventh day, this swelling occupies half the pelvis; and, probably, on the thirteenth day a somewhat free discharge of pus takes place *per anum*. I may allude also to the fact that, after the incomplete amendment which followed the escape

of pus, and the consequent diminution in the size of the swelling, symptoms came on very similar to those of the earlier part of the case, but much more severe and painful. Lastly, I may refer to the rapid and abundant suppuration which occurred at this relapse, as at the first, and soon gave rise to a repetition of the swelling, which again disappeared with the rupture of the cyst and escape of pus per rectum at about the same time as before. After this escape of pus and false membranes, which seemed to contain, as in Case VI., the débris of the ovary and Fallopian tube, both of which, at the *post-mortem* examination, existed only in a broken-up state, there followed a kind of spurious convalescence of a very precarious kind, during which the patient was twice re-admitted into the Hospital; where she finally succumbed to pulmonary consumption.

These last details are here mentioned, because the course which pelvi-peritonitis takes in a phthisical patient during the evolution of the pulmonary tubercle, is an important feature in the diagnosis of orchitis; which, as I have said, may be either simply chronic, or may become chronic from the existence of a tubercular diathesis; or it may be a manifestation peculiar to this diathesis. In the first case, we generally find that the symptoms of chronic pelvi-peritonitis, instead of increasing, rather diminish during the progress of the pulmonary tuberculosis, and the menstrual discharge ceases—while, on the contrary, in the second case, the symptoms continue, and lead on to consumption. The only elements of diagnostic value which, so far as I know, serve to distinguish simple from tubercular chronic orchitis, are the persistence, in advanced consumption, of menstruation, or rather of irregularly periodical metrorrhagia—the pasty consistence of the tumour formed by the softened tubercle infiltrating the ovary or the Fallopian tube—and the greater or less irregularity of the surface of the tumour. The difficulty of diagnosis, though great in the two first varieties of tubercular orchitis which I have described, is much more so in the third and more common, but more important, form of genital phthisis, which I have yet to mention.

In this variety, to which Case VI. belongs, though from necessity it was placed in the first chapter as an instance of tubercular pelvi-peritonitis, the morbid deposit is developed in the generative organs at a more or less remote period, after an attack of pelvi-peritonitis. The tubercularisation sometimes takes place long after an attack of orchitis; sometimes it follows an attack of pelvi-peritonitis, after, it may be, several months or years, seeming almost to be a

relapse of that inflammation. Perhaps the most characteristic evidence of the evolution of tubercle, is the constitutional condition of the patient; but this is so well understood, that I need not now particularise its leading features.

It is equally unnecessary for me to describe the rapidly fatal symptoms which characterise the extension of the pelvic to the abdominal inflammation, as they are the same as occur in the case of purulent pelvi-peritonitis. To this rapidity is probably due the fact, that pulmonary tubercle is not common in these cases; and, curiously enough, the same rule obtains in the male; showing here also a similarity in these homologous affections in the two sexes. An equally rapid fatal termination may, as in the case of Madame Boivin, recorded below,* be brought about by the supervention of acute phthisis. And I might adduce many other examples, but I feel that they are unnecessary; it is sufficient to state that the lungs are the most frequent seat of the tubercular mischief; and I will only add to the sketch just given, that the symptoms of tuberculosis when once fairly established continue prominently up to the patient's death.

There is a variety of pelvi-peritonitis the prognosis of which is even more unfavourable than that of tubercular orchitis; viz., where the peritonitis results from the reaction of cancer of the generative organs upon the serous membrane. This affection, which is analogous to sarcocele in the male, and an example of which is given below,† is so rare, that I am not sure of having seen a single instance of it—I may, however, quote the following case which occurred in

* Case of Madame Boivin, *Mém. cit.* obs. i., p. 3.

Madame K., 27 years of age, caught cold at a ball, and had an attack of inflammation of the chest, for which a good many leeches were applied; the result of this was to bring on a miscarriage at the fifth month of gestation. The pulmonary affection was, in consequence, much aggravated; and she died seventeen days after the abortion.

The *post-mortem* examination showed extensive tubercular pelvi-peritonitis, and tubercular mischief in the lungs.

† Case of M. Forget de Strasbourg, *Gazette médicale de Paris*, 1851, p. 41.

A woman, 62 years of age, was the subject of cancer, which was limited to the body of the uterus. The cervix uteri was quite normal; but in front of the uterus an elastic swelling could be felt, *per vaginam*, which was thought to be encysted dropsy of the ovary. The patient gradually sank and died; and, on making a *post-mortem* examination, it was discovered that what had been thought to be ovarian dropsy was a cancerous mass filled with putrid magma, while the ovaries were both healthy.

the hospital practice of M. Briquet, and at the *autopsy* of which I assisted.

CASE XXV.—*Cancer of the ovary ; pelvi-peritonitis—at first acute, afterwards chronic ; three months afterwards, cancer of the rectum. —Death in six months.*

A young woman, aged 17, came under observation in June, 1856, suffering from acute peritonitis, for which she was treated antiphlogistically. The acute stage passed off, and was succeeded by a chronic form, which was very painful. A tumour developed in the lower part of the abdomen, reaching up to the umbilicus. It was dull on percussion, and obscurely fluctuating, resembling that described in Case XXII. This tumour continued up to the time of her death without any alteration. She came successively under the care of M. Briquet, Rayer, Chomel, and myself ; and none of us could make out any enlargement of the uterus or any tumefaction of the vaginal culs-de-sac. This state of things lasted three months, when fresh symptoms showed themselves. A sero-gelatinous secretion, mixed with blood, came from the rectum ; and, soon after this, cancerous concretions were discovered in that part. These we all thought were caused by the propagation of cancer from the ovary, to which we ascribed the pelvi-peritonitis. In a short time, encephaloid tumours developed in different parts of the body, and from this she sank.

Having considered the subject of cancerous orchitis, which differs so completely from true cancer of the uterus, though the latter often gives rise to inflammation of the pelvic serous membrane, I need only allude to the question of pelvi-peritonitis arising from inflammation of ovarian cysts, though I have several times met with such cases : the inflammation of the cyst is here the predominant feature, and I shall have to discuss this question in the diagnosis of the different kinds of feminine orchitis.

CHAPTER IV.

DIAGNOSIS.

THE varieties of feminine orchitis just described, differ from one another so widely as regards their onset, that we must study each separately, as has been done in the last chapter.

ACUTE PELVI-PERITONITIS.

The greatest difficulty in the diagnosis of the early stage of acute pelvi-peritonitis consists in the extreme variation in the amount of pain, in the symptoms of reaction characteristic of the inflammation, the disagreement between the amount of pain and the severity of the reactionary symptoms; and, lastly, the predominance of some symptoms over others. In some cases, the symptoms of peritoneal inflammation are so severe, that they resemble very closely the ordinary signs of abdominal peritonitis. In others, on the contrary, the symptoms are so feebly marked as to be scarcely appreciable; and mistakes are thus easily made. I may remark, therefore, that if the pain be excessive, if there be no derangement of the digestive organs, and no decided febrile disturbance, then the character of the pain, in the absence of any peri-uterine tumour will suggest the existence of some form of neurosis. In like manner, I may mention that, if the pain is but slight, while the febrile disturbance is severe and of long duration, the idea of continued fever will naturally be suggested. I shall not stay to point out the errors of diagnosis which may arise from a predominance of some of the reactionary symptoms, and especially of the disturbances of the digestive organs. I have already pointed out that sometimes, under the influence of extreme nausea or vomiting, the face becomes blue, the pulse almost imperceptible, cramps come on, and the patient assumes the appearance of a choleraic attack.

I have not dwelt at any length on the difficulties of diagnosis; nor have I thought it necessary to enumerate all the points to be attended to in forming an opinion, because it seemed to me sufficient to remark

upon the possibility of making a mistake in order to avoid it. In like manner, it is sufficient merely to mention the possibility of mistaking sub-acute pelvi-peritonitis for some internal strangulation, or *vice versá*; because cases of this kind are unquestionably very exceptional. For the same reason, I shall avoid any lengthy discussion of the diagnostic features of pelvi-peritonitis, symptomatic of an affection of the generative organs, and that resulting from an affection of the digestive organs. The case recorded below is a very curious instance of this kind, which I collected from the practice of the *Hôpital St. Antoine*.* In all these cases the diagnosis turns upon the predominance of the symptoms referable to either the genital or the digestive organs; and especially as regards the earlier history of the affection.

It is, indeed, in regard to these elementary questions, that the true feminine orchitis may be so easily mistaken. It may be confounded with hæmatocele, with inflammation of an ovarian cyst, or with phlegmons of the iliac fossæ. I must dwell more upon the differential diagnosis of the first and second of these two affections especially that of hæmatocele, with which I shall begin:—

1. DIFFERENTIAL DIAGNOSIS OF ACUTE PELVI-PERITONITIS AND HÆMATOCELE.

This diagnosis, easy as it is in those cases where there is a well defined peri-uterine tumour, is sometimes so difficult, that probably there is no gynecologist, however skilful, who has not made mistakes in this respect, and it would be justifiable to resort to exploratory punctures in order to determine the question. The same difficulty arises in diagnosing simple or purulent from the hæmorrhagic form of pleurisy. In regard to the diagnosis of partial peritonitis symptomatic of an abdominal affection, and pelvi-peritonitis, we shall find that in the one there is a predominance of

* CASE.—An embroideress, aged 29, was admitted into the *Hôpital St. Antoine*, June the 12th, 1844. Two years and a half ago she had a venereal attack, with chancres and a vaginal discharge, for which she was treated with mercury for two years. She then became pregnant, and had a natural labour. A few months after this, diarrhœa came on; then peritonitis, of which she died. On *post-mortem* examination, there were observed tubercles in both lungs, enormous dilatation of the stomach, which was drawn down to the pelvis by adhesions between the epiploon and pelvic organs; the intestine was extensively ulcerated; and both the abdominal and pelvic organs were matted together by adhesions. The pelvic cavity contained a considerable quantity of pus and serum.

abdominal, and in the other of uterine symptoms; besides this, there is the previous history to guide us in discovering which organ was the first to be affected. Difficulties of another kind arise in distinguishing two forms of pelvi-peritonitis both of which are due to an affection of the generative organs. Thus, in hæmatocele, as in pelvi-peritonitis, there is inflammation of the pelvic peritoneum — the difference being that, in the one, the hæmorrhage results from some affection of the generative organs; while, in the other, the inflammation arises from a kind of metastasis of the genital affection to the pelvic peritoneum.

It is not often that there is any doubt as to the evidence afforded by digital examination; but when there is, we must examine not only the characters of the tumour but also the circumstances under which it originated, and the previous history of the patient. Great reserve is necessary when there is a suspicion of hæmatocele, owing to the exceptional character of that affection, especially when compared with the frequency of sero-adhesive pelvi-peritonitis. I have seen many errors of this kind committed; indeed, I have made many mistakes myself. I do not admit the existence of hæmorrhagic pelvi-peritonitis, unless there is not only one, but a complete group of symptoms characteristic of one or other variety of this affection, and unless there be also a full knowledge of all the circumstances which preceded and followed the peritoneal inflammation. Hence, from the differences which exist between the several varieties of hæmatocele, and which are often more marked than those which characterise the various forms of pelvi-peritonitis, we must, in order to decide upon the existence of hæmatocele, analyse carefully the series of contradictions which any given case presents, but which I cannot now enumerate; and, although hæmatoceles may occur at other times besides during menstruation (*vide* Cases XII. and XIII.), I intend to consider simply the differential diagnosis of menstrual pelvi-peritonitis, and the several varieties of hæmatocele to which the term catamenial may with justice be applied, as these are by far the most common.

Menstrual pelvi-peritonitis, as the cases I have recorded abundantly prove, occur either after the suppression of the menstrual discharge, or during, or after, an attack of menorrhagia. Under these very diverse circumstances, it happens that pelvi-peritonitis may be mistaken in the former case for hæmatocele caused by defective excretion; and, in the latter case, for hæmatocele due to difficult secretion. In the former, which I shall first consider, we must carefully study

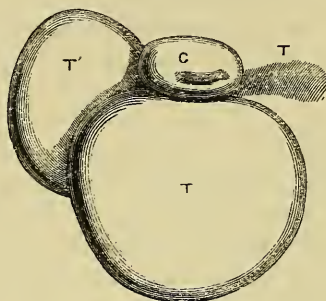
all the circumstances occurring between the period of the arrested discharge and the supervention of the inflammation; for without this precaution we may very easily be led into a wrong diagnosis, as happened in the following case; which I have reserved till now, partly because of the very remarkable characters which the peri-uterine tumour presented, and partly because of the course which the purulent pelvi-peritonitis took; and which presents many analogies to the case of hæmatocele.

CASE XXVI.—*Menstruation regular to the age of 30; abortion at sixth week, followed by leucorrhœa and pains in the right iliac fossa; menstrual suppression from mental emotion, followed by acute pain; formation of a retro-uterine tumour, which increased during the two next periods; escape of pus per rectum, followed by improvement and cure.*

M. L., aged 38, was admitted into *La Pitié*, September the 30th, 1856. She began to menstruate at 14, and continued regular up to the time of her pregnancy at the age of 30. She miscarried at the sixth week; and was ill for some months after, suffering a great deal from pain in the right iliac fossa. In July, 1856, she experienced a fresh attack; which was relieved by hot baths. On the 8th of September, menstruation came on, and stopped suddenly from grief. On the 10th, lancinating pains were felt in the right iliac fossa, unaccompanied by any bearing-down, pelvic, or crural pains. On the 12th, there was added to this, painful tenesmus and difficult defæcation; laudanum poultices were applied, and gave relief. On the 17th, M. Boucher saw her, and made out a tumour in the hypogastrium, behind the cervix uteri; fifteen leeches were applied externally, and repeated next day. On the 3rd of October, the patient was in great pain, vomiting, the tumour in the hypogastrium was enlarged, bilobed above, one part filling the right iliac fossa, the other much smaller, about the size, and in the situation, of the gravid uterus at three months, pressure on which was felt, *per vaginam*; behind the cervix, a hard globular tumour was felt, with an indistinct sense of fluctuation; the rectum was flattened by it. On the 10th of October, four days after menstruation, she was seized with violent uterine colicky pain in the left side, bearing-down pain, and tenesmus; the tumour was much increased in size, and invaded the right iliac fossa; ten leeches were applied, from which she experienced some relief. In the month following, these symptoms reappeared, but with greater intensity.

The abdominal tumour could be distinctly defined, and was markedly increased in size, having assumed one of the forms so common in hæmatocele, as may be seen in the adjoining sketch.

FIG. 13.



C. Cervix posterior to the tumour.
 T. Retro-uterine tumour. T'. Tu-
 mour of the right cul-de-sac. T'' Tu-
 mour of the left cul-de-sac.

The cervix was carried forward, and pushed against the pubis, the os looking backwards and to the left; behind and below the cervix a round globular tumour could be felt, pushing forward the posterior vaginal wall, and pressing the cervix to the left; the tumour seemed obscurely fluctuating. She was ordered lemonade, seltzer water, quinine, and laudanum poultices.

From the 16th to the 22nd of November, the symptoms were aggravated; she was weaker, more emaciated, was troubled with diarrhœa, vomiting, and tenesmus. The tumour was increased in size, extending beyond the umbilicus, and projecting lower into the vagina; but beyond a more distinct feeling of fluctuation, there was no other change in it. She was ordered anti-spasmodics, with opium and quinine.

On the night of the 24th, she passed a large quantity of pus from the bowels, which had the effect of considerably diminishing the size of the tumour, both above and below.

During the following week, she continued to pass pus per anum, and the tumour concurrently diminished, the uterus gradually becoming more normally placed; but the patient's general symptoms increased rather than diminished in severity. On the 3rd of December, the upper part of the tumour was only about four fingers'

breadth above the pubis; the vaginal culs-de-sac were becoming more normal. On the 4th, the discharge of pus and the diarrhœa had considerably diminished. On the 8th, symptoms indicative of the approach of menstruation set in; with them the tumour sensibly increased in size, and became more distinctly fluctuating. Ordered seltzer water, bismuth, and mustard to the thighs. By the 15th, the tumour was again considerably reduced in size, dull, hard, non-fluctuating.

From this time forward, the improvement, though gradual, was continuous; she regained her flesh and strength; the tumour slowly diminished; all discharge ceased; and, on the 4th of February, she left the Hospital. I learned afterwards, that menstruation became regular and painless, and she was able to go about without difficulty. I saw her again in July, 1861; she still continued well; no trace of the tumour could be felt externally or internally; but the uterus was almost completely immovable—it was vertically placed, but occupied the right cul-de-sac, which was small and indurated, as was also the posterior, while the left was increased in size. Examination gave no pain.

I have reported this case at some length, because I was anxious to show how a tumour which results from purulent pelvi-peritonitis may be mistaken for hæmatocele, and to prove that it is chiefly by watching the patient's antecedents, and the circumstances which precede or accompany the peritoneal inflammation, and, lastly, the sequence of the symptoms, that we can determine whether the peritonitis is hæmorrhagic, sero-fibrinous, or purulent. The case proves, too, that the seat and configuration of the tumour, which projected bilobed into the abdomen being somewhat smaller in the middle, like a great many hæmatoceles, and which, *per vaginam*, occupied both lateral culs-de-sac, projecting behind and below the cervix, and occupying the post-pubal region, cannot be characteristic of an intra-pelvic effusion of blood, as M. Aran has asserted.* It proves, further, that the existence of this enormous tumour, with its peculiar characteristics, possesses really a very limited value in a diagnostic point of view, and may even lead to error. Lastly, it proves that the development of a retro-uterine tumour in connection with a menstrual period, unless it is clearly determined, possesses no value in

* Aran, *Bulletins de la Société des hôpitaux*, 1859, t. v. No. 1, p. 35.

the differential diagnosis of sero-fibrinous, or purulent pelvi-peritonitis, and hæmatocele. The frequency of menstrual pelvi-peritonitis, as compared with hæmatoceles, which are exceptionally rare, shows that if, following the opinion of M. Oulmont,* we content ourselves merely with the knowledge of the development of a tumour behind the cervix at a menstrual period, we shall pretty certainly be led into error—an error, probably, which will occur three times out of four.

In making a diagnosis of such a case as this, we must, on the one hand, look to the almost perfect similarity between the characters of the purulent retro-uterine tumour and those of hæmatocele; and, on the other, to the peculiarities which distinguish the case of purulent pelvi-peritonitis from hæmorrhagic pelvi-peritonitis caused by an error of excretion, which in many respects it closely resembles. In this case there were differences in the antecedents of the patient, who, notwithstanding the existence of a kind of uterine constriction, had had no menstrual difficulty, no dysmenorrhœa; while, after an abortion, she had what seems to have been an attack of pelvi-peritonitis, with, at different times, some slight exacerbation. Two months before the menstrual suppression, there was a rather severe return of the inflammation, and any trifling cause seemed to provoke it. There was another point of dissimilarity between this case and hæmatocele from defective excretion; viz., the absence, between the sudden stoppage of the menstruation and the development of the retro-uterine tumour, of any history of dysmenorrhœic pains indicating a distension of the genital organs before the escape of blood into the abdominal cavity. Hence we find that the occurrence of a retro-uterine tumour, after the sudden stoppage of menstruation, in the absence of any symptoms indicative of internal hæmorrhage, such as characterise the rupture of a tube or ovary, argues in favour of a non-hæmorrhagic pelvi-peritonitis. Again, there were in this case none of those changes which almost invariably take place in all blood tumours, viz., inequality of consistence, part being solid and part liquid. Purulent tumours, on the contrary, become more and more uniformly fluctuating. Lastly, the general condition of the patient indicated the existence of deep-seated suppuration, and not hæmatocele; though, as in the very rare case of M. Boucher, quoted below,† these same or similar symptoms have occurred in a case of hæmatocele.

* Oulmont, *Bulletins de la Société des hôpitaux*, 1859.

† Case communicated by Mr. Boucher.

R. G., aged 35, was admitted on the 7th of March, 1861, into the *Hôpital*

I believe that by carefully analysing, as I have done, the familiar features of each case, we may, even in doubtful cases, make out the differential diagnosis of pelvi-peritonitis, whether sero-fibrinous or purulent, and hæmatocele from defective excretion. The diagnosis of metrorrhagic hæmatoceles presents almost equal difficulties, though of another kind, as I shall now proceed to show.

The intra-peritoneal effusion in metrorrhagic hæmatoceles, instead of being preceded by symptoms of catamenial retention, as in the variety which I have just compared with pelvi-peritonitis arising from menstrual suppression, comes on simultaneously with a profuse sanguineous discharge from the vulva, which gives to the patient a peculiar expression. Hence the association of an abundant discharge externally, with a bloody effusion internally, the latter giving rise to an inflammation of the serous membrane, and the speedy formation of a large tumour projecting above into the abdomen, and below into the vagina behind the cervix uteri; these, together, constitute a group of phenomena quite pathognomonic of hæmatocele. Unfortunately, however, they cannot, as I have before said, be regarded as pathognomonic of all forms of hæmatocele, because in some they are wanting, as in the variety which I just now considered.

These symptoms cannot be said to have an absolutely differential value, as regards those cases of pelvi-peritonitis which after labour or an abortion are preceded by an abundant bloody discharge. The rarity of hæmatoceles after labour, whether at term or prematurely, the frequency, on the contrary, of pelvi-peritonitis, sero-fibrinous or purulent, under the same circumstances, constitutes a primary element of differential diagnosis between the two affections. Then, too, the small size of the retro-uterine tumour at the commencement of the former case, compared with the almost instantaneous bulk of the latter,

St. Antoine. On the 12th of February, menstruation suddenly stopped on the second day, and was followed by violent colicky pains in the lower part of the body. She soon became unconscious, and remained so for three days; the abdomen was distended, and very tender. On examination, March the 12th, the uterus was immovable, the cervix pushed forwards and to the left, by a tumour behind it. Diarrhœa came on, a good deal of pus and blood being discharged by the womb. The patient gradually became weaker, vomiting set in, and she died on the 27th of May.

On *post-mortem* examination, numerous peritoneal adhesions existed; the pelvis was occupied by a tumour, which was filled with fœtid pus, altered blood, and lymph; a communication existed between it and the sigmoid flexure; the left ovary and Fallopian tube could not be found; those on the right side were healthy.

is another point of importance. Lastly and specially, must be noted the signs of the hæmorrhagic diathesis, or rather of the disease which creates the diathesis, and is the cause of the intra-peritoneal blood effusion.

An acquaintance with the antecedents of the patient is of yet greater importance in the differential diagnosis of catamenial hæmatoceles and sero-fibrinous or purulent pelvi-peritonitis occurring during menstruation, especially in the acute stage, where there exists a discharge of blood which tends, by its abundance and duration, to confound the two diseases. This importance arises not only from the fact that hæmatoceles of this kind are but an accidental phenomenon of metrorrhagia, but because it is only in relapses of feminine orchitis that we meet with discharges of blood, analogous to that which characterises metrorrhagic hæmatoceles, concurrently with symptoms of acute inflammation of the pelvic serous membrane. The history of previous attacks similar to the present, is of greater value; because relapses, though frequent in orchitis, are very rare in hæmatoceles; and metrorrhagias, symptomatic of chronic orchitis, which are the most common affections in young women, very rarely give rise to effusions of blood into the abdominal cavity.

I must insist upon the relative importance of the peritoneal symptoms in cases of metrorrhagic hæmatocele, and in relapses of feminine orchitis. In the latter, the inflammatory symptoms are well marked, but there is no evidence of anæmia; while in the former, just the reverse obtains. To this difference may be added that observed by digital examination according as the fluid is serum, pus, or blood, and according to the changes which they successively undergo. The fluctuation which exists in the tumour in its early stage, the rapid disappearance of this symptom, the diminution and simultaneous induration of the tumour—all these are suggestive of sero-fibrinous effusion, the result of pelvi-peritoneal inflammation. While, on the contrary, in purulent pelvi-peritonitis the tumour, instead of diminishing, gradually increases in size; it becomes more tense, obscurely fluctuating, assumes more and more the characters of an abscess, while at the same time the symptoms of deep suppuration appear. Lastly, in hæmorrhagic pelvi-peritonitis, there is at first a peculiar consistence which it is impossible to describe—it partakes of the character both of a solid and liquid, and a succession of changes take place in it, owing to the changes which the blood undergoes. When these several changes are well marked they are of great value; but when not, as will be thought to be the case if the sense of touch

be not acute, they may lead to error, unless aided by the patient's antecedents, by the sequence of symptoms, and the progress of phenomena which are the primary elements in diagnosis.

I attach the greatest importance to these last symptoms; not only on account of their great obscurity in certain cases, but because we cannot expect in every practitioner an amount of tactile dexterity which is only to be acquired by daily examination. But even without this dexterity, which, though useful, is not indispensable, these affections may be diagnosed. Moreover, in practice, it does not give rise to much inconvenience if there be some uncertainty as to the differential diagnosis of hæmatocele and purulent pelvi-peritonitis, or of the latter and inflammation of a cyst of the ovary.

2. DIFFERENTIAL DIAGNOSIS OF ACUTE PELVI-PERITONITIS AND INFLAMMATION OF AN OVARIAN CYST.

With regard to the differential diagnosis of inflammation of hydatid cysts of the pelvis, which are of very rare occurrence, I enumerated, in my remarks on Case XLVIII., Vol. I., the symptoms which enable us to distinguish hydatid cysts from hæmatoceles. The great difficulty in the diagnosis of this affection, and of spontaneous, or rather non-traumatic inflammation of ovarian cysts, is due to the infrequency of these affections, and to the ignorance of the patient as to the pre-existence of any tumour; hence they sometimes date the formation of the tumour and the occurrence of the acute symptoms to one and the same period.

The symptoms which characterise spontaneous inflammation of an ovarian cyst and of the neighbouring peritoneum are very similar. Generally, as in the case detailed below,* there is a painful hypogas-

* Case. R. E., aged 36, was admitted into *La Pitié*, December the 19th, 1859. She was pregnant for the first time and aborted at 25; after which she was delivered at term, after a severe, protracted labour. Three weeks subsequently, she suffered severely in the left iliac fossa; leeches were applied, and she recovered. Three years previous to admission she suffered from metrorrhagia; soon afterwards she observed that the abdomen was considerably increased in size, the swelling being principally on the right side. She now became subject to attacks of vomiting and diarrhœa, and she was in almost constant pain about the lower part of her body, which was increased by movement, especially in the tumour on the right side. Per vaginam this tumour was very tender, obscurely fluctuating; leeches were applied, and gave great relief. By a continuance of this treatment, with blisters, opiate, and emollient applications, the pain gradually subsided, the fever diminished, and she left the Hospital relieved, but with the ovarian tumour unaltered.

tric tumour, projecting equally into the vagina and rectum, together with the ordinary symptoms of pelvi-peritonitis.

In cases of this kind we find, as in the case recorded, buried as it were in the peri-uterine induration, an obscurely fluctuating tumour, the characters of which are in general sufficiently well-marked to show that the acute symptoms which the patient suffers are the result of inflammation of an ovarian cyst. These characters are: first, the situation of the tumour, antero-laterally to the uterus, which is the most frequent site of ovarian cysts; secondly, the peculiar form of uterine deviation which this tumour gives rise to; thirdly, the regularly globular form of the tumour itself, its position in the abdomen, and the obscurely fluctuating resistance which is peculiar to these cysts. To these signs may be added the relative mildness of the peritoneal symptoms, compared with the not inconsiderable size of the tumour; and lastly, the maintenance of the same size and general character of the tumour, while the physical signs of the peritoneal inflammation gradually disappear. The physical signs of the cyst itself after the inflammation has subsided, prove that this fluid tumour belongs to a group to which the name of dropsy of the ovary has been given. I shall not insist on this latter point, because it is a matter only of prospective diagnosis, and is liable to lead to error. We may indeed, though unfortunately very rarely, see the cyst not only diminish in size, partly by the inflammatory processes, partly as the result of the antiphlogistic treatment, but become almost inappreciable, as in M. Aran's case, where a *post-mortem* examination revealed the fact; as also in the case recorded below,* which terminated in a cure. But if, on the contrary, the contents of the

* Case published by M. Goupil, in the *Bulletin de la Société Médicale d'Observation*, 1856.

A. H. V., aged 33, was admitted on Nov. the 5th, 1856, into *La Pitié*. At the age of 17, a tumour, which she said had existed in the vagina for six months, became very painful, and then burst spontaneously, discharging a good deal of pus and fœtid blood. Four years before admission, she had a violent attack of pain in the lower part of the body, followed by metrorrhagia; for the last four months menstruation has come on fortnightly, with a good deal of pain. On admission a tumour existed to the right of the hypogastrium; during her stay of a month in the Hospital, she suffered a good deal of pain in and about the tumour, which was relieved by leeches, blisters, and anodyne applications; the tumour also diminished in size considerably, and she was discharged.

cyst suppurate, then all the symptoms of deep-seated suppuration set in; and the result is, either the death of the patient, or a cure, and complete obliteration of the cyst. The extreme rarity of cases of this kind, and the facility of diagnosing this purulent condition of the cyst renders it unnecessary to differentiate them from cases of suppurative pelvi-peritonitis, with which they might be confounded, unless on our guard against a mistake—which happened, I imagine, in the case recorded below,* as far as one can gather from the scanty details.

III. DIAGNOSIS OF PELVI-PERITONITIS AND PHLEGMONS OF THE ILIAC FOSSÆ.

The principal interest in this diagnosis results from the confusion which has been introduced into the history of pelvic phlegmons by M. Nonat; whose opinions, however, were not based upon any *post-mortem* examinations, but were the result merely of a defective induction, inasmuch as they took no cognisance of the fact pointed out by M. Grisolle,† that there are cases of circumscribed peritonitis, acute or chronic, which by giving rise to a swelling, cognisable both to sight and touch, may be mistaken for a phlegmon. The number of *post-mortem* examinations which I have made, especially in those cases of acute pelvi-peritonitis, where, during life, very distinct peri-uterine swellings could be felt, without there being after death any sign of inflammation of the cellular tissue, proves the truth of M. Grisolle's statement. They show very conclusively that M. Nonat has made a great mistake in this matter, while reference to the dates of the two publications removes all possibility of excuse on the ground of ignorance. The omission, in M. Nonat's cases, of all mention in the records of the *post-mortem* examinations, of the details

* Case of M. Nonat, *loc. cit.*, obs. xviii., entitled, *Phlegmon péri-utérin à gauche. Foyers multiples*, etc., p. 783.

A young girl, 18 years of age, was admitted into *La Pitié*, March 12th, 1852. At 17, she had an acute inflammatory attack on the left side of the pelvis; where, on admission, a tumour could be felt, immoveable, solid, non-fluctuating, tender. She died suddenly of croup on the 26th.

On *post mortem* examination, the uterus was found pushed to the right by a tumour on the left. On section, the tumour was found to be multilocular, and contained pus and serum; the left ovary was completely destroyed; the right healthy.

† Grisolle, *Histoire des tumeurs phlegmoneuses de la fosse iliaque*. (*Arch. génér. de méd.* 3^e serie, t. iv. p. 294, 1839.

necessary to determine the intra- or extra-peritoneal seat of the purulent pelvic collections, the existence of which he barely mentions, makes the conclusions drawn from them perfectly useless.* To go more at length into this question would occupy too much space, as it would be requisite to criticise seriatim the five fatal cases published by M. Nonat;† and I am unwilling thus to exhibit their many defects, some idea of which may be gathered by reading the sample of them which is recorded in the note in the preceding page.

But enough, what I have said is even more than I intended to say, but I regard it as absolutely necessary to prove that the researches of M. Nonat, notwithstanding their undoubted advance, which I am quite ready to allow, start from this erroneous hypothesis; viz., that every peri-uterine swelling which, to the touch, presents somewhat the characters of a phlegmon, is a phlegmon. For my own part, I have only met with one case of phlegmon of the iliac fossa in a non-puerperal woman, which could be ascribed with any reason to an indefinite genital affection; and even that one, which is briefly recorded below,‡ is not at all convincing, because the phlegmon, if such it was, terminated by resolution, and was moreover only a relapse of a similar, but then puerperal affection, which two years previously had required the introduction of the lancet to give exit to the matter.

I may remark that the result to which the study of genital affec-

* Nonat, *loc. cit.* obs. xii., p. 710, et. obs. li., p. 793.

† Nonat, *loc. cit.* obs. xlvi., p. 779; obs. xlvi., p. 782; obs. xlvi., p. 783; obs. xlix., p. 785; obs. li., p. 793.

‡ C. G., aged 29, was admitted into *La Pitié*, June 1st, 1861. After her first labour, in 1856, she had an acute inflammatory attack; from which, however, she seems to have perfectly recovered. Her second child was born in December, 1858; and, a week after, she had a repetition of the abdominal pain, and other symptoms indicative of pelvic inflammation. From this she again recovered, went out, and had a relapse; the pain now being principally in the right iliac fossa, where a swelling could be felt parallel with the Fallopian tube, but not projecting into the vaginal cul-de-sac. After a time, fluctuation was felt in the centre of the swelling; and, as it appeared very superficial, it was opened, and a quantity of pus evacuated; the tumour gradually diminished in size, and became harder; and the patient finally left the Hospital. She now became subject to metrorrhagia, and some symptoms of phthisis developed themselves. The pelvic and abdominal pains again returned after some exertion, being most severe in the right iliac fossa, as before. Leeches were applied, and by rest and suitable treatment she recovered, the swelling gradually disappearing by resolution, and menstruation returning normally as before.

tions has led me is in agreement with the opinion of M. Grisolles,* as regards the subject of phlegmons of the iliac fossa, and to differ with M. Nonat.† In this view I am supported also by M. Valleix; ‡ who, however, together with M. Gallard,§ draws a distinction between puerperal phlegmons, and the affections to which they gave the name of peri-uterine phlegmon. Their observations led them also to the conclusion that the latter condition is a very rare one in the non-pregnant. I consider, therefore, that this united yet independent testimony establishes beyond doubt the extreme rarity of non-puerperal pelvic phlegmon, while cases of pelvi-peritonitis, on the other hand, the peri-uterine phlegmon of Valleix and Gallard are very common, and constitute a primary and important element in the diagnosis of inflammation of the pelvic serous membrane. In fact, it follows that, in doubtful cases, where there co-exists also some affection of the generative organs which may re-act upon the neighbouring parts, we ought rather to infer the existence of pelvi-peritonitis, than of phlegmon. Inflammations of the cellular tissue are in general easily distinguished from pelvi-peritonitis; in most cases by the different characters of the swelling to which these two affections give rise; and in those rare cases where the swelling presents, perhaps, some analogous characters, then, by the marked difference in their symptoms, which I shall now consider.

In the first place, when the pelvi-peritonitis is so moderate as to give rise to symptoms analogous to those of phlegmon, the swelling, which is clearly appreciable in one or more of the vaginal culs-de-sac, does not rise above the brim of the pelvis, nor does it reach yet to either iliac fossa. When it is distinguishable in the hypogastrium, which is a very rare occurrence, it is only at the last, when it has increased by successive attacks, and this does not happen with phlegmons. The swellings to which these latter give rise, scarcely within reach, as they are, of the vagina, from their being flattened against the horizontal processes of the pubis, become on the contrary, appreciable in the hypogastrium almost from the first; that is to say, as soon as the inflammation has extended from the neighbouring cellular tissue to that of the iliac fossa. They form in the abdomen, but not in the vagina, a greater or less swelling, according as the cellular tissue of

* Grisolles, *loc. cit.* p. 37.

† Nonat, *loc. cit.* p. 244.

‡ Valleix, *Guide du médecin praticien*, 4^{me} edition, *loc. cit.*

§ Gallard, *Thèse cité.*

the abdomen or psoas muscle is involved. Hence, as regards situation, consistence, shape, and progress, there is a marked difference in the two cases, which I need not further particularise. I must, however, as a matter of practical importance, point out that suppuration is not infrequent in phlegmons, whereas it is very rare in pelvi-peritonitis.

Purulent, or sero-adhesive pelvi-peritonitis, when it is sufficiently severe to give rise in a few days to a swelling, similar to that of a phlegmon—that is to say, one cognisable, per vaginam, as well as by abdominal palpation in the iliac fossa—is more easily distinguished from a phlegmon than that we have just considered. The diagnosis rests upon the existence of the general symptoms of peritonitis in the one case, as compared with those of inflammation of the cellular tissue in the other. These symptoms are generally well marked and are now pretty well understood. Moreover, the tumours themselves possess very distinctive features; the intra-abdominal site of the peritoneal, distinguishes them from phlegmons of the superficial iliac fossæ; and, where the deeper iliac region is involved, there is generally retraction of the thigh, which does not exist in pelvi-peritonitis. In the latter case, too, there is a want of definition in the swelling felt in the iliac fossa, which involves also part of the middle hypogastric region. Where the uterus, from being more prominent than usual, can be readily felt, the middle and lower part of the tumour, the base of which is in the vagina, behind the uterus, forms a retro-uterine swelling, such as is not met with in phlegmons. Lastly, the elastic sort of resistance of this swelling, which at first presents a kind of obscure fluctuation, a feeling very difficult to describe, but peculiar to tumours containing fluid, differs from the solid swellings of true phlegmons. Phlegmons of the iliac fossæ are very rare in the non-pregnant; and their diagnosis is far easier at the bed-side, than the length of the discussion to which I have been forced would lead one to suppose.

Unfortunately, it is not always thus easy after parturition; for, when the symptoms begin within a few days after labour, the diagnosis is then often very difficult; the signs, both of phlegmons and of pelvi-peritonitis, are, under these circumstances, obscured by those of the puerperal fever to which they are subordinate. We can thus easily understand how the accoucheurs of the last century may have classed, under one head, these two affections; especially as both may give rise to the formation of pus in the shape of abscess.

The differential diagnosis of these two affections, where the puerperal fever is uniform and of moderate severity, approximates that of the

non-pregnant state. The elements of this diagnosis are : first, the initial abdominal pain is remote from the labour in phlegmons, near to it in pelvi-peritonitis ; secondly, in the former, the febrile reaction exceeds in severity the disturbance of the digestive function, while the reverse obtains in the case of the latter ; thirdly, the different characters of the two swellings. Thus, in pelvi-peritonitis the inflammation comes on generally within ten days after delivery, while in phlegmon, eighteen or twenty days will elapse, the case up to that time being, or appearing to be, normal. In puerperal pelvi-peritonitis, the initial stage is generally ushered in by a rigor ; in phlegmon this is wanting. The pain, though in both it is similar as regards its situation, its radiations, its being equally affected by pressure and movement, differs in that, in serous inflammation, it is acute, sharp, resembling that of pleurisy ; while, in inflammation of the cellular tissue, it is dull, occasionally lancinating, like that of the first stage of abscess. Lastly, in pelvi-peritonitis the expression is pinched, there is greater prostration, and more febrile disturbance. These last, however, are sometimes not very well marked.

The swellings symptomatic of pelvi-peritonitis are distinguished from those produced by inflammation of the broad ligaments by their situation, by the deviations which they impress upon the uterus, and by their physical characters. But the swellings produced by inflammation of the broad ligaments are not appreciable during life, or even after death, as M. Siredey has pointed out,* until the disease involves the cellular tissue, either of the abdominal wall, or of the psoas muscle, and has produced a swelling in the iliac fossa, which differs in the two cases. In the former, the swelling, which is scarcely, if at all, to be felt per vaginam, differs from that which obtains in peritonitis, not only by the absence of any projection into the vagina behind the cervix, but by its rising superficially above the pelvic brim. This latter, which is generally more on one side than peritoneal swellings, is not very thick in proportion to its length. Indeed, if the *fascia propria* alone is involved, the existence of any phlegmon may sometimes be overlooked.

The swelling of a phlegmon, which is dull only on very superficial percussion, has its upper border so clearly defined, that when the extreme sensibility has passed away, we can push the abdominal wall behind it, as it were. In peritonitis, on the con-

* Siredey, *Thèse inaugurale*, p. 21.

trary, the swelling is not parietal; it rises out of the pelvis, escapes the middle line, and carries the fundus uteri forwards, and to the healthy side. Hence, from the different situations of these tumours, arise marked differences in their physical characters; inasmuch as, per vaginam, peritonic swellings have at first very much the same consistence as phlegmons; while that part which emerges into the abdomen never exhibits the characters which are common to the iliac swellings of true phlegmons. These differential characters become more marked as the tumour progresses; in the one the growth is regular, though it varies according as it terminates by resolution, or by suppuration, or by induration; while, in the other, it takes a course which would appear abnormal for a phlegmon; because, in cases of sero-adhesive peritonitis, the inflammatory process seems to be perpetuated by constantly-recurring attacks of an acute form, determined by slight causes. It is possible also, having regard to these various elements of differential diagnosis, to distinguish during life pelvi-peritonitis and phlegmons of the broad ligaments invading the cellular tissue of the abdominal walls; which seem to be rather a puerperal affection of the ovaries and Fallopian tubes, than a deep-seated phlegmon of the iliac fossa.

True phlegmons of the broad ligaments seem frequently to be a kind of early manifestation of the puerperal fever itself—a sort of critical abscess; and, like the phlegmons of the superficial iliac fossæ, they have many points both of resemblance and of difference with pelvi-peritonitis. The hypogastric swellings, characteristic of both affections, have these points in common; they are deep-seated, they push aside the intestine so as to fill the iliac fossa; and neither the one nor the other show, at first, any very marked sign of phlegmon, which will appear subsequently in inflammation of the cellular tissue, but be absent altogether in cases of pelvi-peritonitis.

Then, again, the swellings, if there be no special circumstance hindering an examination, as occurred in the case reported below,* will be

* Case of M. Brouardel.

L. M., aged 21, was admitted into *La Pitié*, April 13th, 1859. Her first labour was natural; but, at the end of a week, she experienced pains in the legs, loins, pelvis, &c.; and had the general symptoms of pelvic inflammation. The pains were most acute in the left iliac fossa, and in the lower extremities, which became œdematous (phlegmasia dolens); she had obstinate vomiting and colliquative diarrhœa. An abscess subsequently formed in the iliac fossa, and made its way externally in the sacral region,

found to differ in regard to their configuration, and their progress towards the abdominal walls. In the case of pelvi-peritonitis, the tumour emerges from the pelvis upwards and outwards; while, in inflammation of the psoas muscle, the swelling takes place along the upper border of the crest of the ilium and the Fallopian ligament, and thence towards the middle hypogastric region. Besides all this, there is an absence of any vaginal swellings; at any rate, at first. I have often spoken of this negative sign, in speaking of phlegmons, but I do not attach great importance to it; because, in July last, I saw a woman who died of erysipelas in the course of a puerperal phlegmon, and in the last days of her life, an induration occurred on the left side of the uterus, but higher and less easily reached than that which occurs in the course of pelvi-peritonitis. It was caused, in that case, by a plastic infiltration of the cellular tissue of the broad ligament. But, besides the phlegmonous swelling which filled the iliac fossa, and which after death was found to contain an enormous collection of matter, there was another purulent collection, resulting from an extension of the inflammation to the cellular tissue of the mesentery. It was interposed between the two layers of the iliac meso-colon, rested above the broad ligament, and was readily discoverable by examination.

Having already pointed out the uselessness of the hypothetical reasoning of M. Nonat, and having shown, by numerous cases, that the chronic or sub-acute peri-uterine indurations are intra-peritoneal, it is unnecessary for me to trace the differential diagnosis of these phlegmons and pelvi-peritonitis, which are one and the same disease. I do not deny that inflammation of the cellular tissue of the broad ligament may terminate in induration, as in the case of Dr. West already quoted;* and may then give rise to a swelling on

where it discharged a good deal of pus. Hectic fever supervened, and she gradually sank, and died on the 14th of May.

On *post-mortem* examination, the peritoneum and abdominal organs were all healthy; a fluctuating swelling existed in the left iliac fossa—this proved to be from a large collection of pus, which had burrowed among the iliac muscles; the broad ligaments, ovaries, and Fallopian tubes were healthy; the uterus was anteflexed, but otherwise healthy, except about the circular sinus of the cervix which contained pus. The crural veins were obliterated by a clot, which had the appearance also of containing pus in it.

* Case recorded in note, p. 36.

one side of the uterus, which is cognisable to the touch. I only deny, because it has not been established by any *post-mortem* examination, that these inflammations of the broad ligament give rise to the symptoms of spurious chronic peri-uterine phlegmons, as sketched by M. Nonat, which are, in fact, only modifications of the inflammation of the pelvic serous membrane. In the two cases which I have recorded in order that I may not be accused of omitting any fact which may seem to contradict my opinion, the induration of the broad ligament did not give rise to any pain or functional disturbance sufficient to attract the notice of Dr. West and M. Aran, both of whom were interested in observing them; inasmuch as these two cases might really weaken the argument of my first memoir. These two exceptional cases, incomplete though they are, prove that inflammatory lesions of the peri-uterine cellular tissue are not so ephemeral as M. Nonat, for his own special purpose, says they are; but they only supply us with this one deduction; viz., that inflammation of the broad ligament has no proper distinctive sign when it terminates in induration; and that the symptoms of this affection are entirely different from those of chronic or sub-acute peri-uterine phlegmons, which, from the cases I have reported, may be regarded merely as varieties of pelvi-peritonitis.

IV. DIAGNOSIS OF CHRONIC PELVI-PERITONITIS AND ENGORGEMENTS OF THE UTERUS.

The difficulty of diagnosis, or rather of describing the diagnosis of cases of chronic pelvi-peritonitis, some of which, at their outset, begin more or less acutely, while others come on very insidiously, is owing to the obscurity of those morbid affections with which they may be confounded—for example, uterine engorgements, deviations, fibrous tumours of the uterus, and hysteralgia. The difficulty is, perhaps, greatest as regards the first of these, which I will take first in order, because the distinction drawn between these two affections by our immediate predecessors, marks an epoch in the study of gynecology; and because, also, the knowledge of this differential diagnosis is necessary to the understanding of the others.

Engorgement of the uterus, *à propos* of which one may truly say that what we really know is but little compared with what we do not know, is generally easily distinguished from pelvi-peritonitis. The distinction consists especially in the configuration of the swelling,

which arises from the increase of the uterine parenchyma. The diagnosis is easier when the increased volume, whether it be the result of congestion, or inflammation, or simply malnutrition, is uniform throughout all parts of the uterus. This regularity in the enlargement, its consistence, which is pretty much that of the normal uterine tissue, its mobility, and the regular transmission of all movements impressed on it from above—all these establish the diagnosis. They do not, of course, tell the nature of the uterine engorgement; but they prove that the case is not one of chronic pelvi-peritonitis which has come on insidiously. Nor is the diagnosis difficult when the uterine engorgement is associated with tubo-ovarian varix, a condition which, during menstruation, and when the hæmorrhage symptomatic of this hæmorrhoidal condition of the genital organs, gives rise to a kind of semi-fluctuating tumour beside the uterus, which disappears with the flux. The irregular outline of peritonic tumours, their different characters, their consistence, and the grooves which exist between the peri-uterine indurations and the womb, are sufficiently differential signs. The finger, also, as M. Nonat, to whom belongs the honour of making this diagnosis, has pointed out, discovers that the swelling is due to true engorgement of the uterus (chronic parenchymatous metritis of certain authors), which may occur after many or painful labours, or at the time of the mid-period. The existence of a bearing-down feeling, or disturbances in the menstrual function, argues nothing for this opinion, since these symptoms exist in both affections. The presence of uterine catarrh does not militate against it, as it exists so frequently in cases of engorgement, that it has been regarded by some as the cause of one of the varieties of parenchymatous metritis.

Unfortunately, the tumours do not always present so clearly the characters above-mentioned. They may be obscured, either because the enlargement of the body of the uterus is relatively partial; or because, in addition to the uterine engorgement, there is pelvi-peritonitis, which is not uncommon in puerperal cases. In the former case, it is generally easy, by a careful examination of the swelling, to discover that this, which exists most frequently on the posterior wall, is really part of the uterus, and not the result of any peritoneal adhesions. In the latter case, an examination of the swelling, having regard to the marked changes which rest and treatment effect in one part of it, while that which belongs to the hypertrophied cervix itself is little, if at all, affected—these, with a careful consideration of the

history since the commencement of the affection, will enable us to estimate the part borne by the pelvi-peritonitis, and that of the uterine engorgement respectively. All this, however, requires very great digital aptitude, and a considerable experience of each affection, independently of the other. Without this, there is great risk of attributing the phenomena to one or other of these affections, and of neglecting that which may perchance be the most important of all.

V. DIAGNOSIS OF UTERINE DEVIATIONS.

Combined internal and external examination, by which we may recognise the position of the fundus uteri, will equally enable us to distinguish, from the abnormal resistance to which version or flexion of the uterus gives rise, the majority of indurations produced by chronic inflammation of the pelvic serous membrane; because we generally find sufficiently marked differences between them to enable us to form a judgment. Nevertheless, in some cases, the diagnosis is a matter of great difficulty, especially if we trust entirely to physical signs. Such is the case when the peritonitic tumefaction is limited to one of the vaginal culs-de-sac, more particularly the posterior; or when it is so adherent to the uterus, that it seems as if it were retro-verted or -flexed; or, especially, where there is pelvi-peritonitis, in addition to the uterine deviation, thus giving the characters of both those affections.

These are some of the difficulties which led observers to attribute to uterine displacement the symptoms which Lisfranc regarded as due to morbid tumefaction of the organ, and thus created no little nosological confusion. It is entirely owing to this confusion that, under the name of uterine deviations, is comprised a great many, if not all, the cases to which M. Lisfranc applied the vague term of engorgement, and which has apparently rendered necessary a plan of treatment suitable to such a denomination. Hence, in complex cases, other elements of diagnosis are requisite than those merely which are furnished by touch. The antecedents of the patient, the relation of the several symptoms, and the functional disturbances to which they are subject, and which are not due to the uterine displacement.

VI. DIAGNOSIS OF FIBROUS TUMOURS.

The diagnosis of chronic pelvi-peritonitis and fibrous tumours is, in spite of the obscurity of the pathological history of the latter,

generally pretty easy ; so easy, indeed, in the majority of instances, that to those who have met with cases in which this was the rule, it may seem singular that M. Nonat* and I should dwell so much upon this question. The difficulty, in cases of this kind, arises, on the one hand, from the excessive hardness which peri-uterine deposits acquire after a time, and from their close contiguity to the uterus itself, becoming almost a part of its structure ; and, on the other hand, from the frequency of menorrhagia or hæmorrhagic attacks, which increase when the patients become cachectic.

We may then mistake the peritonitic indurations implanted on the uterus for fibrous tumours, whose characters they resemble ; and the sense of pelvic weight, the pains—and, most of all, the hæmorrhages, which are so prominent a feature in these cases, may also be erroneously referred to the existence of these spurious fibroids. This mistake once happened to me, in the case of a woman who, under the influence of a genital affection, was partially paralysed in the lower extremities, bladder, and rectum. More than two months, however, after the commencement of the paraplegia, a large quantity of pus escaped per rectum, and thus compelled me to recognise my error. We may believe, too, as I did in another case, that chronic pelvi-peritonitis has been caused by a fibrous body, part of which seems to have all the characters. In the case I refer to, part of the swelling, about the size of a pigeon's egg, intimately adherent to the upper part of the posterior wall of the cervix, and projecting into the rectum, was separated by a groove, and by its great hardness, from the rest of the swelling, which was manifestly formed by inflammatory products. Moreover, the physical characters of the indurated portion of the swelling made me think it was a fibrous body, and to this I ascribed the extremely painful dysmenorrhœic attacks. Happily for the patient, time proved that I was wrong. Not only after the application of some leeches, did the attacks cease, and the peripheral portion of the swelling gradually disappear, but, under the influence of rest for five or six months, and a tonic regimen, the supposed fibrous body disappeared, and the patient got well. These errors in diagnosis, which may explain many supposed cases of fibrous tumour, and even of cancer of the uterus, were caused by my attaching too much importance to physical signs. It was not, however,

* Nonat, *loc. cit.* p. 281.

till after many careful examinations that I made my diagnosis, and this proved to be incorrect, because I had not sufficiently observed the commencement of the illness, which both patients referred to their previous confinements.

We learn from these two cases, that where the diagnosis is difficult, from the extreme hardness of the peri-uterine tumour, from the irregularities of its surface, and from the bosses projecting from it, we must not form our opinion merely upon examinations per vaginam and per rectum. We must discuss successively all the symptoms, especially the character of the pain, its exacerbations, and whether these periodic attacks are attended by changes in the swelling, which is almost always the case in pelvi-peritonitis. We must also study the relation of the symptoms indirectly connected with the genital affection, such as the paraplegia, which existed in one of the cases first referred to—in order that we may find out their origin, because this relation may be an important element in diagnosis. Sometimes these fibrous tumours may, under the influence of an accouchement, either at the time of labour, or at the return of menstruation, be the starting-point of an attack of pelvi-peritonitis, as happened in the case recorded below.*

But, notwithstanding all our investigations, the case may still be doubtful, especially when the patient has for a long time previous to the attack been subject to irregularities of menstruation, more particularly to menorrhagia, and where repeated attacks of hæmorrhage form the

* CASE.—E. A., aged 28, was admitted into *La Pitié*, 3rd January, 1848. In 1835 she was delivered of her second child, still-born, at the eighth month. All went on well till three months after, when, from a fit of passion, menstruation suddenly ceased, and a tumour was developed in the right iliac fossa, which rapidly attained a considerable size, and became very painful. At each succeeding month, these pains increased, though menstruation did not return. She recovered, became pregnant, and aborted with twins at the sixth month. She became pregnant again, and aborted February, 1842; after which she suffered from metrorrhagia. Again she fell pregnant, and was delivered in November, 1847. She menstruated the following month; and again it was suppressed by a fit of passion, which was followed by the most acute suffering, and other symptoms indicative of general peritonitis, of which she died on the 23rd. On *post-mortem* examination there was found general purulent peritonitis; the intestine was healthy. The uterus enlarged, by the presence of a tumour, the size of a foetal head; several other smaller fibrous tumours existed in the uterus. The ovaries and Fallopian tubes were healthy, as was also the vagina.

principal feature of the case. It may also be impossible, for some time, to determine whether or no the indurated nodules are fibrous bodies. We must determine, too, whether we ought not to attribute to these organic products, the menorrhagia antecedent to the pelvi-peritonitis and the pelvi-peritonitis itself; or whether, on the contrary, the peritoneal affection is not merely a consequence of the disturbance of the catamenial function induced by age, and whether its long continuance has not caused a kind of *cartilagination* of the exudative products.

VII. DIAGNOSIS OF HYSTERALGIA.

The constant occurrence of a cachectic condition in the last stages of pelvi-peritonitis, and the close connection between the genital functions and the nervous system, explains the frequency of the functional derangements under these circumstances, and the relation which exists between the nervous and inflammatory phenomena, when the latter are in any way aggravated. Not only do these two orders of phenomena require to be described in the symptomatology, but their distinctive characters, though essentially different, are so intimately connected with one another, that they ought to receive attention. Hence, it is not necessary to trace the diagnosis of the nervous phenomena which accompany the inflammatory symptoms in cases of chronic pelvi-peritonitis. I have already very carefully sketched the diagnosis of hysteralgia in the chapter on symptomatology, and shall not, therefore, refer to it again. I need only repeat that the differential diagnosis of this tic-doloureux of the genital organs, is founded upon the special characters of the painful crises; on the particular form of the general reaction; and lastly, on the coincidence of other functional derangements, connecting the hysteralgia either with hysteria, or with chlorosis, or with anæmia. I should add, however, that these differential characters are of no value, unless we can demonstrate the absence of all periterine induration.

CHAPTER V.

TREATMENT.

PELVI-PERITONITIS presents itself under so many forms that no one plan of treatment can be laid down, either for the acute or chronic variety; it is a condition symptomatic of such diverse affections, that the therapeutical indications must vary, also, according as it is acute or chronic, purulent or sero-adhesive, and as regards also the affection which precedes it, and the constitutional peculiarity of the patient; indeed it is impossible to define all the special circumstances which the practitioner will have to consider; but I will endeavour to review as many as I can.

I. ACUTE OR SUB-ACUTE VARIETY.

And first, of the acute or sub-acute form. The treatment in these cases very much resembles that required in ordinary peritonitis, or in the early stage of hæmatocele, which I have already considered in the previous volume.

For the first few days, the life of the patient is often in great peril. The treatment should therefore be the more urgent, as any delay may admit of the inflammation extending to the abdominal peritoneum, if it does not soon terminate fatally. At the same time, we must be sparing in the use of leeches, especially in puerperal cases. We must also avoid applying them to the cervix, because of the pain and fatigue which they occasion; one or both iliac fossæ is the best place under such circumstances. Twenty-five or thirty leeches, followed by poultices or fomentations, will generally be found of great service; and these may be repeated in eight or ten hours, except in those cases where the powers of the patient are much enfeebled. It is rarely that a third application will either be necessary or desirable; but if the improvement be not sufficiently marked, a large camphorated blister over the whole abdomen will be beneficial.

With the first application of leeches, I usually order one-tenth of a grain of opium every hour until narcotism is produced, maintaining afterwards a slight degree of somnolency. This I recommend for the double purpose of allaying the sickness, and for the specific action which opium seems to have in peritoneal affections. We must be careful against being deceived by the state of somnolency into the belief that the patient is really better than she is, and so withhold other remedies which may be required. I entirely object to the employment of purgatives of all kinds in the first stage of the disease. Rest, both general and local, is of the first importance in these cases; hence my objection to purgatives. At the same time, if the bowels are so confined that the hardened fæcal matter forms a sort of obstruction, then an enema applied with a long tube, so as to reach beyond the pelvis to the seat of accumulation, will be advantageous. As regards diet, the nearer this is kept to a state of starvation the better.

Supposing, now, that the patient does not die in the first two or three days, a serious question will arise, if, as happened in Cases III. and XXII., there be detected either, *per vaginam*, or in the hypogastric region, a distinct feeling of fluctuation. The question is, whether an opening for the discharge of the serum which fills the pelvis will not relieve the parts, and prevent an extension of the inflammation to the abdominal peritoneum; but, though I know of no facts condemning this practice, yet I think it will be found more prudent to wait until there is pretty certain evidence of the presence of pus.

II. PURULENT VARIETY.

When suppuration has taken place, and symptoms of hectic fever have supervened, it is generally admitted that an opening for the escape of pus must be made. The condition of the patient is, indeed, under these circumstances, so serious, that we should be justified in resorting to almost a dangerous proceeding to rescue her from imminent death. This opinion is not mere theory, but is fully borne out in practice. In three cases of the kind which I have seen, death resulted in one from an extension of the inflammation to the abdominal peritoneum (Case III.); in another, though for a time the patient seemed to be relieved by the matter escaping *per rectum*, yet she finally succumbed to colliquative diarrhœa (Case XXII.); while, in the third, also a puerperal case, the matter came away *per rectum*, and the patient recovered.

In the less acute forms of purulent pelvi-peritonitis, the practice of making an artificial opening is not so generally accepted, as the symptoms are not usually so urgent, and the matter may perchance find its way either through the rectum, vagina, or bladder. In six cases of this kind which I have met with, the results were as follows : In two, the patients made a quick recovery ; in two, they recovered, but much slower ; in the fifth, symptoms of a most severe character were suddenly relieved by the spontaneous escape of matter per rectum ; in the sixth, the patient died two months after the peritoneal cyst had opened into the bladder. From all I have observed of these cases I think we ought not to leave entirely to nature the question of the evacuation of pus. That we ought not to press it too urgently, but wait till its presence is clearly manifest, and then let it out. It is much better to make the opening per vaginam, than per rectum, and still more by the iliac fossæ. I do not approve of the employment of injections of any kind into the cyst, as practised by Recamier ; a fatal example of this kind is recorded below.*

The possibility of general peritonitis following the simple injection of water, supplies an *à fortiori* objection to the employment of iodine in this way, either for the purulent or sero-adhesive form, as recommended by Demarquay.† It is far better to enjoin perfect quiet, the use of poultices and emollient applications, and the treatment of symptoms as they arise, improving the diet and giving tonics, as the acute symptoms subside. We must, however, be on our guard against any recurrence of acute symptoms when the next menstrual period comes round.

* Case of M. H. Bourdon, *loc. cit.*, p. 42.

F., aged 26, was delivered naturally, March 1841. It was followed by a good deal of pain in the hypogastric region, which was increased by pressure. On examination, a tumour was felt in the broad ligament, fluctuation was detected in it ; and, after a while, an incision was made into it through the abdominal wall, when a quantity of pus escaped. The cyst was then injected with water, when this was followed by rigors, and symptoms of acute peritonitis ; and she died on May the 30th. On *post-mortem* examination a good deal of sero-purulent matter was found. The viscera were matted together, and small collections of pus existed between them. One of these had opened into the rectum, another into the thorax. A tumour, the size of an apple, existed in the left broad ligament. The uterus and appendages were quite healthy.

† Communicated to the Institute, August 5th, 1861.

III. SERO-ADHESIVE VARIETY.

It is rare for the symptoms of this form, to resemble in severity those of ordinary peritonitis; and it is seldom necessary, therefore, to resort to a very antiphlogistic plan of treatment. But, unfortunately, after the first application of leeches, the pain often continues just as severely; and we may be obliged to repeat them, though in less number. In this variety, we may apply them direct to the cervix, which is, I believe, by far the best place for the application of leeches in cases of pelvi-peritonitis. If, however, digital examination gives much pain when the uterus itself is touched, then it is best to avoid the use of the speculum. I believe that four leeches applied to the cervix is as good as three times that number applied externally; for, not only is it nearest to the seat of inflammation, but the relief to all the genital organs is greater. I do not think even scarification can be compared with leeches in point of utility; the amount of blood drawn off is, comparatively speaking, quite insignificant; and there is the possibility of serious consequences resulting, as in the case mentioned below.*

The only danger, on the contrary, from the use of leeches to the cervix uteri when local depletion is necessary, lies in the possibility of one of them creeping up into the uterine cavity; generally, however, they soon come down again; but the result is more injurious than beneficial; I must say, however, that I have never met with such an instance, though my collaborator M. Goupil has. It occurred in the *Hôpital Beaujon*, under the care of M. Barth; and the same accident occurred to M. Besnier and also to M. Siredey. In the two last cases, the leeches came away again spontaneously some short time after, when the patient was in a warm bath, having previously caused

* Case of M. Aran, *loc. cit.*, p. 647.

This was a case of a woman, 30 years of age, who had suffered for a considerable time from chronic pelvi-peritonitis. On the 4th of September, 1857, the cervix uteri was freely scarified for congestion and hypertrophy; in a few hours rigors came on, followed by symptoms of local peritonitis, which subsequently became more general; and, notwithstanding vigorous antiphlogistic treatment, she died on the 17th. On *post-mortem* examination, there was evidence of extensive peritonitis, the uterus was anteflexed, and there were adhesions in all directions. The sub-peritoneal cellular tissue about the cervix was considerably thickened; there was nothing remarkable about the other organs.

her a great deal of hysteralgia. Still, even these cases are not sufficient to alter my opinion as to the general utility of leeches.

In cases complicated with the existence of chancrous ulceration of the cervix, much good may result from the addition of mercurial inunction over the body; not, however, if carried to the extent of salivation. Much good will also follow the employment of terebinthinate preparations, in cases of blenorrhagic pelvi-peritonitis. It cannot be too often repeated, that pelvi-peritonitis is essentially a symptomatic affection; and hence the treatment must vary according to the nature of the affection of which the inflammation is a result. In the first stage, the most important point for consideration in the more chronic diathetic or cachectic cases, is the avoidance of too free leeching, and a too severe dietary. This applies more especially to venereal cases, which are generally all the better for a little stimulation.

The necessity for watching carefully the return of menstruation, is perhaps greater in cases of the sero-adhesive than in the purulent variety, as the former are more liable to relapses. In this variety, to which M. Gosselin has given the name of sub-acute relapsing phlegmon, we must, as soon as there is any indication of inflammatory action being lit up, such as slight increase of the peri-uterine swelling, increased tenderness, or heat, or pulsation, at once have recourse to leeches to the cervix in order to relieve the congestion, and to bring on the catamenial discharge. This, followed by a warm bath, will generally produce a good result, especially if the discharge really comes on well. It is rarely necessary, unless the menstruation fails to come on or comes on very scantily, to repeat this leeching; for, if the pains still continue, a succession of flying blisters will generally succeed best. We must be careful, however, not to do too much, to avoid fatiguing the patient, and not to be over anxious about the complete cessation of the pain; at least, until some little time has elapsed. Absolute rest in bed, laudanum poultices, a bath every three or four days, and the administration of about half-a-grain of powdered conium every day, with a carefully regulated diet; this makes up the general plan of treatment required in the second stage of this disease, the majority of cases getting quite well again by the second menstrual period.

Possibly I may have exaggerated the length of time required for the patient to keep in bed. At any rate, I have done so in good faith, and with the desire of doing the best for the patient. To sum up, then, I should say that leeches first, opium and emollient applica-

tions next; then flying blisters, the regulation of menstruation, proper diet—and perfect rest, these constitute the best plan of treatment for these cases; to which must be added the treatment indicated by the nature of the affection of which the inflammation is a symptom. We ought, however, studiously to guard against inducing a state of anæmia.

Of the above-mentioned plan, there is no one point which I think is so important as that of absolute rest in bed. There should be no movement whatever of the genital organs, and it will be found that a hypogastric bandage or support affords very marked relief. I know of none better than those represented in these illustrations:—

FIG. 14.

FIG. 15.

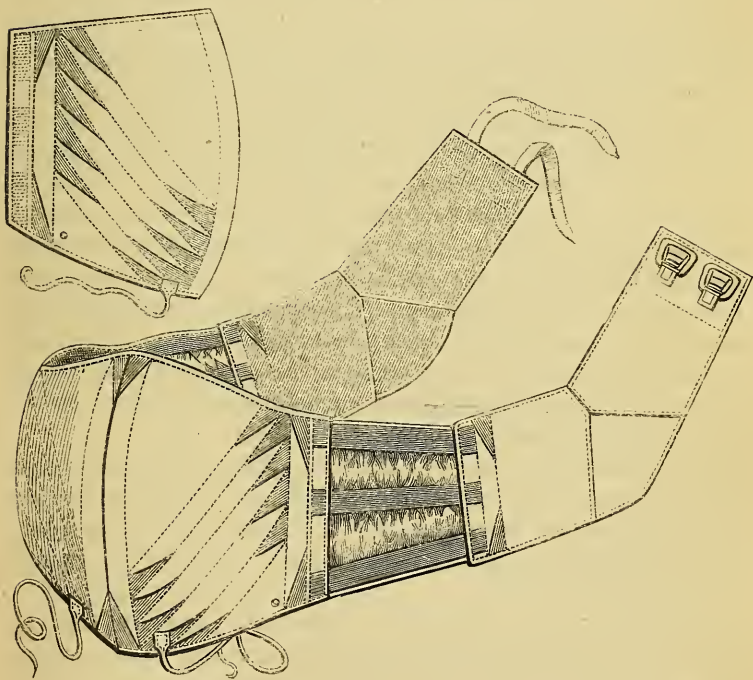


Fig. 14 represents the central portion of the corset, and Fig. 15 the entire apparatus. It should be made of strong coutil, half thread and half cotton; in the centre, two bits of whalebone will be required, to give it the curve of the abdomen; and one on each side, to adapt it to the shape of the iliac fossæ; having, laterally, pieces of elastic to

facilitate the movements of the body. Lastly, there should be understraps, formed of caoutchouc tubing, to pass under the perineum, and be attached to the belt behind and before for the purpose of keeping it *in situ*.

This bandage, I think, serves the same useful purpose as the suspensory bandage in orchitis of the male. It should be worn for some time; in fact, as long as fatigue causes pelvic pain; for I regard the maintenance of a state of immobility of the pelvic organs, at least as far as practicable, as a matter of great importance.

IV. CHRONIC PELVI-PERITONITIS.

In the treatment of chronic pelvi-peritonitis, it is unnecessary to remark that I reject entirely the application of leeches, which have been pompously described as derivatives, or revulsives, and the enforcement of a rigorous system of dieting.* I believe, on the contrary, as I have often said in this work, that we must not only nourish the patient well while in this condition, but we must be very reserved in the employment of leeches, especially where there is reason to suppose that the continuance of the affection is due to a constitutional peculiarity of the patient. It must not, however, be inferred from this, that I reject all local depletion in these cases; I only mean that we should use caution. Of course, if the pains be severe, leeches are the proper remedy, subject to the restrictions before-mentioned; if, on the other hand, revulsives are called for—flying blisters, with a little morphine ointment, if there is any suspicion that the pains are of a neuralgic character, will afford great relief.

In those cases where there has been any excess in the sanguineous discharge, and the patient is reduced to a state of anæmia, absolute rest in bed is of the first importance; and, next to this, the employment of anti-hæmorrhagic remedies, such as lemon-juice, or rhatany, but not ergot.

Should these means fail, a blister over the iliac fossa will often be of service in arresting the discharge. Baths are, of course, contra-indicated, unless they are medicated.

I have thought that, in cases where the nervous phenomena predominated, hydrotherapeia, wrapping up the patient every day in a damp sheet, for the purpose of encouraging perspiration, would have a very beneficial effect. Alkaline baths, Vichy water with the meals,

* Nonat, *loc. cit.*, p. 298, 308.

sulphur baths, and the administration of sulphur water internally, in cases of a scrofulous habit, will do good. And, lastly, arsenical baths, and the administration of Fowler's Solution internally in rheumatic cases, especially in those subject to arthritis, or cutaneous eruptions, will do good. I need not, however, nor indeed can I, enumerate all the variations of treatment necessary in the several varieties of chronic pelvi-peritonitis.

I ought to add that I have found conium a most valuable special narcotic to the genital organs. I give it so as just to produce slight derangement of vision, and a kind of hallucination. I have, however, seen many cases get quite well without there having been any apparent effect from the administration of the drug; so that I cannot feel certain that the beneficial results which seemed to follow its employment were really due to that.

Considering the general condition of these patients, I have not thought the employment of iodide of potassium desirable. At the same time, it is, no doubt, useful in cases where the peri-uterine swelling has assumed the characters of a fibrous deposit.

V. TUBERCULAR PELVI-PERITONITIS.

Scrofula is the great and most frequent cause of the continuance of pelvi-peritonitis. Indeed, in scrofulous subjects, pelvi-peritonitis not infrequently becomes the starting-point of tuberculosis; which, latent before, may develop itself either in the lungs or the genital organs in the first or second stage.

Under the first head, chronic orchitis is simple, and has a tendency to get well, since the progress of the pulmonary affection, by suppressing the menstrual discharge, removes one of the most frequent causes of relapse. In these cases, as regards the pelvi-peritonitis, the principal indication we have to fulfil, is to remove the patient from circumstances likely to favour intestinal disturbances, which are so common in tuberculosis. I will only make one remark in reference to the treatment of tuberculosis; which is that at the onset of this pulmonary phthisis, we ought not to regard the existence of the chronic pelvi-peritonitis as any bar to the employment of such mineral or other waters as may be deemed advisable. Even the fear of the patient being fatigued, and so having a slight relapse of the peritoneal mischief, must not operate against such treatment, which will probably only do good at a particular stage of the tubercular disease, and might be mischievous at any other.

Under the second head ; namely, in cases of tubercular disease of the genital organs, we very rarely have the opportunity of sending the patient to the waters ; because, in the great majority of cases, instead of being beneficial, it just precipitates the progress of the disease. Generally, when the existence of tubercle in the genital organs is shown by the occurrence of pelvi-peritonitis, we can only resort to palliative remedies, which may, at least, soothe the last days of the patient, just as in the case of cancer. It would be superfluous for me to enumerate what is required under these sad circumstances. I will only remark that where there is evidence that the presence of matter is causing hectic fever, we must, though we cannot hope to cure the patient, endeavour to prolong life by giving exit to the matter. I dare not indulge the hope of seeing any such case get well ; still there are circumstances which may inspire a ray of hope when the constitution of the patient, in spite of the existence of a pelvic fistula, maintains a fair amount of strength, as in the case communicated to me by my colleague M. Gosselin, which I append in the note below.*

I believe that in analogous cases, that is to say, where, from the progress of the pelvi-peritonitis being abnormally latent, and the tendency to suppurate not being marked by any inflammatory reaction, we may suspect the tubercularisation of the genital organs before any sign of pulmonary tubercle is manifest—then we may hope, if not for a cure, at least for more or less of permanent improvement.

* Case communicated by M. Gosselin.

A young woman, 25 years of age, had for some time suffered a good deal in the lower part of the body ; pain being increased by pressure and by movement. No fever, no diarrhœa ; a tumefaction could be felt, deep, ill-defined, hard and resisting, apparently in the right broad ligament. She had never been pregnant. At the end of two months, fluctuation was detected ; an incision was made, and a quantity of fœtid pus escaped. Some time afterwards, it was discovered that iodine, which had been injected into the tumour by the hypogastrium, was escaping per rectum. A few weeks later, a quantity of pus escaped spontaneously, per vaginam. Pulmonary phthisis was gradually developed ; and within a year and a half from the commencement of the illness she died. On *post-mortem* examination, in addition to the thoracic lesions, the pelvic organs were found in one complete mass. Between the uterus and rectum, a tumour the size of an orange was discovered, containing a mass of cheesy matter ; the left ovary could nowhere be found. The left Fallopian tube was obliterated at its free extremity. The right tube and ovary were healthy, as also the uterus and other organs.

Under such circumstances, the thermal waters of the Ems in summer, and in the winter one of the stations of the Midi, may be the means of at least prolonging life, and sometimes even of effecting a cure.

But I only make allusion to these exceptional cases, in order that the physician may not lose courage, even with those cases which seem to be desperate. With greater reason may this be said of the cases which I have now briefly to remark upon, in which, though the pelvi-peritonitis may be hardly appreciable to the touch, or the signs are such that we cannot attribute to them the severe pains of which the patient complains, yet their existence is embittered by sufferings which render all movement next to impossible.

VI. TREATMENT OF THE NEUROSES OF PELVI-PERITONITIS.

In a certain number of these cases, the genital affection indirectly gives rise to various hysterical symptoms, to which the patients were previously liable. I need not allude to the fact that, in a great number of others, the genital affection induces a hypochondriacal tendency; so that in the one a nervous condition, hypochondria, and in the other a similar nervous affection, hysteria, is the cause of those terrible crises of pain which are the despair of both the patient and the practitioner. It is evident, from all I have stated in this work, that we must attack these neurotic affections, if we wish to cure the patient. I have only to add, for the last time, that we must not in these cases have recourse to blood-letting for the dispersion of the peri-uterine indurations: these will certainly not disappear for a very long time, and may not disappear at all. We ought equally to abstain from all alterative medication; such, for instance, as the iodide of potassium, which sometimes seriously affects the patient's constitution. On the contrary, while recommending the patient to avoid everything which may lead to a return of the pain, and combating this sometimes by the use of revulsives, among which may be classed electrical faradisations, sometimes by topical applications containing opium, or chloroform, or any other anæsthetic, which we must constantly vary, we must try to sustain their vital power as much as possible. It is in this way that salt-water baths, hydrotherapeia, with all its various applications, which I cannot now specify, the thermal, alterative, sulphurous, and other waters, according to the particular idiosyncrasy, residence in the country, and all those general hygienic suggestions which I need not, and cannot here enumerate, do good. In choosing these reme-

dies, we ought to pay particular attention to the general condition of the patient—reconciling, if that be possible, the prescription to the patient's taste; but never lending oneself to any bold system of medication which some women earnestly seek for; and still less having recourse to such measures as those employed in the treatment of uterine deviations, the consideration of which will form the subject of the following memoir, which, as I said in the preface, is entirely the work of my collaborator and friend, M. Goupil.

PART II.

UTERINE DEVIATIONS.

CHAPTER I.

GENERAL OBSERVATIONS.

THE early writers, as Moschion, Cléopâtra, and Trotula, were well aware that the uterus suffered displacement; and they attributed many of the symptoms of hysteria to this condition. In later times, the opinion was held, that uterine deviations caused pain and grave functional disturbance; but Cruveilhier and Paul Dubois threw such doubt upon it, that even Valleix,* the last defender of the older views, says, "some deviations of the uterus, both congenital and acquired, are unaccompanied by any pain or morbid symptom." M. Depaul† goes further; and in his report, declares that there are but a few rare cases in which the uterine deviation is of any consequence, or requires direct treatment. When "Interne" at the *Lourcine Hospital*, I examined the uterus of every patient, whether admitted for uterine or venereal disease; and I came to the conclusion, that simple flexions and versions do not give rise to any morbid symptoms: nor are they of consequence, except when complicated with uterine or peri-uterine disease; while prolapsus and procidentia occasion peculiar symptoms, but are not of that importance which is usually ascribed to them. Since that time, I have verified my opinion in other hospitals. The statistics, however, in this chapter, are founded on 229 cases observed in the *Lourcine*—in addition to which, eighty-five patients were admitted during the same period—some presenting complications, the symptoms of which could not fairly be attributed to the deviation; while, in some, the state of the

* Valleix, *Leçons cliniques sur les déviations utérines recueillies et publiées*, par T. Gallard, Paris, 1852; p. 6.

† Depaul, *Rapport, à l'Académie de médecine*, Paris, 1854, (*extrait du Moniteur des Hôpitaux*, p. 79).

puddenda prevented exploration, and some were pregnant. I intend here to treat only of deviations of the unimpregnated uterus.

Huschke,* Boullard,† Depaul,‡ and Cusco,§ have endeavoured to fix the normal position of the uterus in the fœtus, girl, and woman. In the fœtus, ante-flexion is the normal direction, though exceptions are found; in girls, before menstruation, the rule continues, but the exceptions increase. After puberty, ante-flexion and ante-curvature exist in rather more than one half.

The following table shows these points more clearly:—

* For notes referred to in this Table, see following page.

| | Anteflexion. | Antecurvature. | Anteversion. | Laterversion. | Latroflexion. | Retroversion. | Petroflexion. | Straight. | Total. |
|---|--------------|----------------|--------------|---------------|---------------|---------------|---------------|-----------|--------|
| Fœtus. | | | | | | | | | |
| Autopsies by (*) M. Lorain. | 6 | 4 | | | 11 | | 2 | 2 | 25 |
| Children. | | | | | | | | | |
| Autopsies by (†) M. Soudry. | 41 | | 11 | | | 17 | 2 | | 71 |
| Children. | | | | | | | | | |
| Autopsies by (‡) M. Goupil. | 14 | | | 7§ | | | 5 | | 26 |
| Virgins | | | | | | | | | |
| from 17 to 27 yrs. | | | | | | | | | |
| Autopsies by () M. Aran. | 6 | | | 1 | | 2 | | | 9 |
| Women nulliparæ, from 17 to 30 years. | | | | | | | | | |
| examined by (¶) M. Depaul. | 3 | | 7 | | | 4 | 4 | 32 | 50 |
| Women nulliparæ, examined by (* *) M. Gosselin. | 16 | 11 | | | | | | 18 | 45 |
| Women nulliparæ, examined by M. Goupil. | 41 | 24 | 14 | 7 | | 2 | 8 | 19 | 115 |
| | 127 | 39 | 32 | 15 | 11 | 25 | 21 | 71 | 341 |

* Huschke, *Encyclopédie anatomique*, traduction Jourdan, p. 438.

† Boullard, *Thèses de Paris*, 1853, pp. 12 et 13.

‡ Depaul, *Bulletin de l'Académie impériale de médecine*, 1854, p. 639.

§ Cusco, *Thèse pour le concours de l'agrégation*, 1853, p. 16.

After pregnancy, the axis of the uterus corresponds with that of the brim of the pelvis, as shown by autopsies made by Aran, Richet, and myself; I shall, therefore, call this the *normal* position, in order not to separate the congenital from acquired flexions.

| | Ante- flexion. | Ante- version. | Latero- version. | Retro- flexion. | Retro- version. | Normal. | Total. |
|----------------|-------------------|-------------------|---------------------|--------------------|--------------------|---------|--------|
| * Aran . . . | 7 | 1 | 2 | 2 | 0 | 4 | 16 |
| † Richet . . . | 11 | 7 | 5 | 3 | 2 | .33 | 61 |
| Goupil . . . | 19 | 37 | 18 | 9 | 4 | 27 | 114 |
| | 37 | 45 | 25 | 14 | 6 | 64 | 191 |

The uterus, after pregnancy, is much more subject to retroversion and to “falling;” and when “normal,” it occupies a lower position.

When the uterus is “normal,” the fore-finger, passed along the axis of the vagina, as far as the cervix, touches the anterior lip, and immediately below it the os; carried forwards, it traces the anterior surface of the cervix; and, by depressing the vaginal cul-de-sac, the surface of the body, often concave, will be found continuous with it. Of this, only a portion can be felt directed obliquely upwards and forwards towards the anterior abdominal wall; carried backwards, the finger touches the posterior lip, enters the posterior cul-de-sac of the vagina; and, depressing this, traces a small part of the posterior part of the body. On each side the borders of the uterus can be followed to a very limited extent.

The uterus changes its position according to the movements of the patient; when she lies‡ with the legs drawn up, the cervix approaches

* Aran, *Archives générales de médecine*, année 1858, t. i. p. 313.

† Richet, *Anatomie chirurgicale*, Paris, 1857, p. 719.

‡ In France, a woman is always examined lying on her back, and not, as in England, on her side.—ED.

Notes referred to in Table, p. 170 :—

* *Le registre des autopsies faites en 1853, à la Maternité.*

† Aran, *Leçons sur les maladies de l'utérus*, Paris, 1858, p. 981.

‡ *Autopsies faites à l'hôpital des Enfants*, 1854.

§ Two of these were anteversions as well.

|| Aran, *Archives générales de médecine*, année 1858, t. i. p. 313.

¶ Depaul, *Rapport à l'Académie*, 1854.

** Gosselin, quoted in the report of M. Depaul.

the vaginal orifice.* I have measured as accurately as possible the distances from the ostium vaginæ to the projecting cervix, and the anterior and posterior culs-de-sac; I marked with the nail of my left fore-finger the depth to which my right finger penetrated, making an allowance of three-eighths of an inch, and being careful to avoid errors arising from the yielding of the vaginal walls or of the uterus. The measurements are not, of course, exact; but their frequent agreement in the same individual, and in similar cases, makes them of some importance; they enable us to escape such mistakes as the confounding elongation of the cervix with "falling of the womb," and they have assisted me greatly in rectifying certain wide-spread and erroneous opinions on the subject of ante- and retroversions.

The cervix in nulliparæ is a small truncated cone, in length from fifteen to twenty millimetres (7^{'''} to 9^{'''}), varying according to the point of insertion of the vaginal walls; its antero-posterior diameter is twenty-two to twenty-five millimetres (10^{'''} to 12^{'''}), the transverse being about two to three millimetres more. In multiparæ, the diameters are from twenty-four to thirty-one millimetres (1^{''} to 1^{''} 3^{'''}); and, in exceptional cases, reach from forty to forty-five millimetres (1^{''} 7^{'''} to 1^{''} 10^{'''}).

In nulliparæ, the woman lying on her back, the average distance from the ostium vaginæ to the cervix, is fifty-five millimetres (2^{''} 4^{'''}); and never less when normal than forty-eight millimetres (2^{''}); to the anterior cul-de-sac, sixty to sixty-two millimetres (2^{''} 6^{'''} to 2^{''} 7^{'''}); and to the posterior, seventy-five to eighty millimetres (3^{''} 1^{'''} to 2^{''} 6^{'''}). These measurements agree with those given by Legendre, in his *Iconographic Atlas*, from dissections of the frozen subject.

In the standing posture, the uterus often sinks a little, two to five millimetres (1^{''} to 3^{'''}); sometimes the body inclines forwards, and the cervix backwards, the movements being natural and unconscious. These dimensions are the same in the multiparæ when supine, though the volume of the cervix and size of the os are different; but, when standing, the cervix and vaginal culs-de-sac approach the vulvar orifice from five to ten or twelve millimetres (3^{'''} to 6^{'''} or 7^{'''}).

These movements are natural, and must not be confounded with a certain displacement of the uterus—sometimes though rarely met with—when one day it is retroverted and the next anteverted the

* Malgaigne, *Anatomie chirurgicale*, Paris, 1838, t. ii. p. 352.

patient being conscious of some internal motion ; the cause, according to Valleix,* is distension of the bladder or rectum, or movement of the intestinal convolutions. This oscillation should not be mistaken for those changes in the direction of the uterine axis as compared with the pelvic to which we give the names of ante- retro- or latero-versions.

* Valleix, *op. cit.*, p. 65.

CHAPTER II.

ANTEVERSION.

ANTEVERSION may be looked upon as an exaggerated state of the normal inclination of the uterus; and we find it, as might be expected, very frequent. By itself, it gives rise to no inconvenience; and any functional disturbance is due to congestion, caused either by some inflammatory condition, or by an excessive mobility of the uterus.

1. Anteversion is far more common after pregnancy than before; thus, out of fifty-one cases, only fourteen (27·4 per cent) had had no children. In these the cervix looked backwards, and was farther than the normal distance from the vulvar orifice; the anterior cul-de-sac was more or less obliterated, while the posterior was either unaltered or diminished from the tension caused by the swinging forwards of the uterus. By measurement from the vaginal orifice, the cervix was distant fifty-eight millimetres instead of fifty-five, the anterior cul-de-sac fifty-two millimetres instead of sixty-two. In eight of these patients the standing posture caused no alteration. In three, the cervix retreated farther back, while the body sank lower in the vagina, so that the anteversion was still more marked. In three, the cervix came down, and the anterior cul-de-sac resumed its normal depth. Out of the fourteen, only three suffered from occasional pains which could be referred to the deviation, but two of these had besides pelvi-peritonitis; while the third, who had vaginitis, did not suffer until the inflammation had extended to the uterine mucous membrane; the pains disappearing with the blenorrrhagia, while the anteversion remained.

CASE I.—*Chancres; granular vaginitis; erosion of the cervix; roseola; uterine catarrh; uterine pains and enlargement after menstruation; muco-purulent uterine catarrh; cure.*

B. M. aged 22, was admitted into *Lourcine*, November 14th, 1854. Menstruation began at 15, and though generally irregular

gave her no particular pain, but she suffered a good deal from headaches. Had never been pregnant.

On admission, an intertriginous eruption existed about the thighs, buttocks, perineum, and labiæ; a greenish purulent discharge came from the vagina; and chancres were seen on both labiæ, not indurated. The vagina and cervix were very red and tender to the touch. Neapolitan ointment was ordered to be rubbed in; and in a few days the eruption disappeared: the chancres had healed by the beginning of December.

As slight symptoms of salivation appeared, the treatment was discontinued. An attack of roseola came on, which seemed to have the effect of checking the vaginal discharge; at least, it stopped soon after. On examination, December the 10th, the uterus was found to be completely anteverted, but quite moveable. A few days after, some muco-purulent discharge was seen to issue from the cervix, which was very red. The mercurial treatment was accordingly resumed. On the 27th, menstruation came on normally. When this had ceased, the cervix was still seen to be very red and discharging, though the vagina was normal. The cervix was also denuded of epithelium and granular. Uterus not enlarged, movement caused pain, especially in walking; ordered rest and opium poultices to the abdomen. She gradually recovered, lost all pain, the chancres disappeared, and she was discharged January 13th.

I lay stress upon this case, because it demonstrates that the pains were due to inflammation; and is an answer to those who, being unaware of the pre-existence of any deviation, attribute the symptoms to it, and not to the disturbance arising from inflammation or menstrual retention, &c., as happened in the note recorded below.* Thus in the case of M. Piachaud, the patient suffered pains due to

* Piachaud, *Thèse*, Paris, 1852, obs. ii., p. 68.

Anteversion; engorgement; treated with a tampon of charpie.

M. R., aged 21, was admitted into *La Charité*, Dec. 13th, 1850. She seems to have had some sort of pelvi-peritonitic attack in connection with the establishment of menstruation when she was about 15 years old. Had never been pregnant. Just before admission, she had an attack of metrorrhagia, which stopped suddenly with great pain. On examination, the uterus was found completely anteverted and a good deal enlarged. A tampon of charpie was placed behind the cervix uteri so as to push it forwards. This was renewed daily; and the result was that the cervix assumed its proper place, but the uterus itself became anteflexed.

sudden stoppage of the menses, a month before her entry into the hospital; and, hence, the abdominal tenderness and uterine enlargement, were signs of a derangement other than the mere uterine deviation. Of the two cases where pelvi-peritonitis complicated the anteversion, in one the deviation was unaccompanied by pain previous to the peritonitis; and though, in the other, there was no previous suffering, yet this is no proof that peritonitis did not exist. As regards the pains of the acute stage, every one will refer them to the peritonitis; and the frequent desire to micturate, the pelvic distress, the lumbar pains during convalescence from walking or fatigue, are well known consequences of the peri-uterine tumours of pelvi-peritonitis. If we carefully examine such patients, we shall find that uterine catarrh exists; the uterus itself is fixed and anteverted by peritoneal adhesions; and this immobility continues, whether the patient lies or stands. Lateral motions impressed by the finger cause distress, and are very limited; any attempt to thrust the uterus into the normal position being attended with the same characteristic sharp pain, which is felt in the acute stage of peri-uterine inflammation. In addition to all this, I may observe that I have found these same pains persisting in convalescents from pelvi-peritonitis, where the uterus preserved its normal and ordinary position. This is easily accounted for, when we consider the persistence of the uterine catarrh; the congestion of the uterus and its appendages reacting upon the peritoneum, and on the adhesions which bind the uterus or ovaria to the bladder and rectum. We can also readily understand how this mal-position embarrasses the functions of the adjoining organs, when the uterus, by its adhesions, hinders free motion of the pelvic viscera. Then adhesions may originate chronic pain, just as pericardial or pleuritic adhesions disturb the functions of the heart or lungs.

We see then that in multiparæ, simple anteversion does not cause functional disturbance; and that, when any such exists, it is due rather to some pathological complication, which may be recognised by its appropriate symptoms and anatomical characters. Now, as the absence of morbid symptoms prevents the diagnosis of anteversion, it is hardly worth while to search out its causes. I certainly do not consider those ordinarily assigned, viz., shocks, strainings, &c., of much importance; at the same time there are some causes which appear quite demonstrable, as, when the cervix* is adherent by

* Ameline, *Thèse*, Paris, 1827, n^o. 55, obs. xiv., p. 43.

ciatrisation to the posterior wall of the vagina, or there are adhesions from old pelvi-peritonitis. Anteversion being far more common in multiparæ than in nulliparæ,* pregnancy may be said to be a predisposing cause, and I shall now therefore examine these cases.

As M. Gibert † remarks, it often exists in multiparæ without giving rise to any functional disturbance.

In most cases ‡ where pain is complained of there is a history of past pelvi-peritonitis which so commonly occurs after labour; still there are exceptions to this rule, as where the uterine congestion or puerperal metritis is doubtful, and where, though the symptoms originate after labour, it is hard to know whether they belong to the deviation, or to that numerous and varied class of diseases which are summed up under the vague title, *engorgement*.

In the mother who has not suffered from pelvi-peritonitis, but whose uterus is anteverted, it is often extremely mobile and readily changes its position, not only to the touch, but by any change of posture. In such a case, if any complication increases the volume or sensibility of the organ, a good deal of distress ensues.

In two only out of twenty patients who had anteversion, uncomplicated with pelvi-peritonitis, the uterus remained in the same position, both in the recumbent and standing postures, and these had no uterine distress. In four other patients, the anteversion, which was very marked while recumbent, diminished on standing, the uterus becoming almost "normal;" the distances from the vaginal orifice to the cervix were sixty-six, and fifty-seven millimetres respectively, while that of the anterior cul-de-sac did not alter. None of these women had any uterine pains; and, in one, this was the more remarkable, because she was of a scrofulous habit, the cervix being enlarged and leucorrhœa existing, while menstruation, which appeared late, was always irregular.

In nine women, anteversion was increased by the standing posture. Seven of these made no complaint of any uterine distress, even after fatigue. Four of them had syphilitic leucorrhœa, but no other disease; one had dysmenorrhœa; but I do not believe that the

* Of 115 nulliparæ, I found the uterus anteverted in fourteen (twelve per cent.). Of 114 mothers I found thirty-six anteversions (31 per cent.).

† Gibert, *Bulletins de l'Académie impériale de médecine*, novembre, 1849, p. 148.

‡ Of thirty-six mothers with anteversion, sixteen had suffered from pelvi-peritonitis.

anteversion was the cause of this, or that it could so flatten the uterine canal as to give rise to menstrual retention; while the other exhibited the whole group of symptoms usually referred to uterine deviation.

It is as well, I think, to quote the following case, in order that we may see what was the cause of this difference in the symptoms, since the amount of anteversion and mobility of the uterus was neither more nor less exaggerated than were the eight others, who yet had no functional disturbance.

CASE II.—*Natural labour; followed in a fortnight by bearing-down pains; leucorrhœa; menstruation regular, but abundant.—Anteversion; ulceration of the cervix, and uterine catarrh.—Rest; employment of sponge pessary; great improvement.*

L. B., aged 24, was admitted into *Lourcine*, under the care of M. Bernutz, March 20th, 1855. Menstruation began at 11. She married at 18, and was delivered of her first child at 19. A fortnight after, she complained of weight and bearing-down; menstruation came on a month after, and has since continued regularly and very freely. Sexual intercourse has been painful ever since. She has tried a great many plans of treatment, both local and general. Has never had venereal disease of any kind. On admission, she complained a good deal of lumbar, sacral, and pelvic pains of a bearing-down character, which were much increased by walking. A round pessary had been tried as a support, but failed, the prolapsus continuing. Defæcation was painful; no dysuria. Rest gave relief.

On examination, the cervix looked downwards and backwards; it was large, soft, ulcerated and patulous; the fundus looked forwards, and could be felt above the pubis (anteversion). On coughing, the uterus, especially the fundus, was driven downwards, the organ being exceedingly moveable. On attempting to replace it, some difficulty was experienced, but no particular pain. The uterus felt heavy and congested. Rest, tonics, and astringent injections were ordered.

She was examined again on the 1st of May; and, though she had much improved in regard to the pain and local discomfort, yet the uterine deviation was little if at all better. A small sponge was accordingly introduced behind the cervix, so as to push that part forward. This she bore for some time, with evident benefit; but some months afterwards, though she expressed herself as decidedly

more comfortable, the uterus remained in about the same situation as before.

This may be regarded as a typical case. We have here an assemblage of symptoms, to each of which prominence will be given according to the bias of the physician's mind: thus, one will refer them to the anteversion, another to the "falling of the womb;" a third to the abnormal mobility of the uterus; a fourth to the *ballotement* of the uterus; a fifth to the ulceration of the cervix; and a sixth to the uterine catarrh or congestion. I shall briefly examine each of these points. The superficial ulceration of the cervix may be at once dismissed from consideration, for the symptoms existed just the same when it was absent as when it was present; and here I may remark that this condition of the cervix often accompanies uterine catarrh, and disappears on rest being observed, without requiring any cauterisation or other local applications.

The anteversion was no more than we found existing in fourteen other patients, who had no morbid symptoms; and the same may be said of the "falling of the womb," and of its mobility; while, as to the ballotement to which M. Chassaignac attributes the distress which follows fatigue or walking, the suffering came on in this patient only on standing for a short time; therefore, the mobility and *ballotement* are not of themselves sufficient to account for these symptoms. There remains, then, only the uterine catarrh and congestion; and it is a question whether the catarrh does not necessarily induce congestion, just as urethral blenorragia is followed by turgescence of the penis. In the case before us, we find catarrh and congestion progressing, *pari passu*; after prolonged rest, the discharge diminished; and, at the same time, the violet tint and increased volume of the cervix disappeared. The pains and bearing-down did not return till after some fatigue, when the leucorrhœa also reappeared; thus it seemed to require a certain amount of time for the uterine congestion to return and bring back the pains. In addition, we see that the pains increased notably a few days before the catamenia; just, in fact, when uterine congestion was at its height. We may notice too, that the dull, aching, wearing, long-continued pains, and "bearing down," are symptoms analogous to the suffering met with in certain cases of varicæ and hæmorrhoids; and that those occupations which require a good deal of standing and violent efforts, as in washerwomen for example, predispose to varicose legs and uterine affections. May not, then,

the uterine pains be due to varicæ of the broad ligaments, or to ovarian varicoceles? We know, with M. Gaillard,* that intense congestion of the uterus, when its position is normal, produces the very symptoms attributed to "deviations."

Admitting then, the importance of uterine congestion, we can understand how these patients' sufferings are always increased by standing, by shocks, and by uterine mobility. We find this condition existing chiefly in multiparæ; especially when, from some puerperal attack, or from some exertion having been made too soon after confinement, there is the state known as subinvolution of the uterus. Deviation in nulliparæ escapes notice, unless some local inflammation occurs, while multiparæ are predisposed to uterine congestion. At the same time, we recognise the influence that the mobility and displacement of the organ, the relaxation of its ligaments, and the great venous development, may have on the congestion; and how arrangements for steadying and supporting the uterus, by abdominal belts or vaginal pessaries, may greatly relieve the patient's sufferings.

In common with others, and especially with M. Aran,† I have observed many cases, where the uterus was so mobile, that it was anteverted on standing, and retroverted on lying down, the vaginal walls being also very lax. All these persons had had one or more children; and they referred the origin of their sufferings to what happened a few days after their confinement, when they complained of epigastric and lumbar distress, of dragging pains at the groins, of inability to walk, and of some constipation; while menstruation lasted longer than before pregnancy, and sometimes became menorrhagic. On examination, the uterus would be found enlarged, and pouring out a copious catarrhal discharge, sometimes of a muco-purulent character. Often superficial ulceration of the cervix exists; and, sometimes, soft fungoid granulations, which bleed readily, may be detected on visual examination.

CASE III.—*Natural labour; followed, after a rather long convalescence, with pelvic and hypogastric pains; leucorrhœa; anteversion; retroversion in the recumbent posture; improvement from the use of a sponge pessary.*

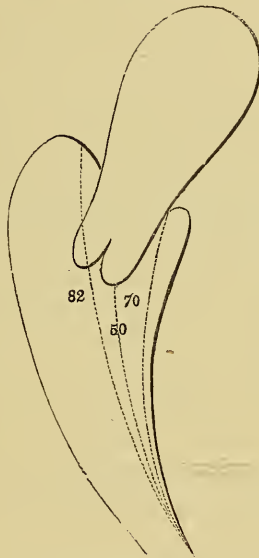
M. P., aged 21, was admitted into *Hôtel Dieu*, September 9th, 1859. She began to menstruate at 14, was married at 19, and was

* Gaillard (de Poitiers) *Bulletins de l'Académie de médecine*, 30 Avril, 1854.

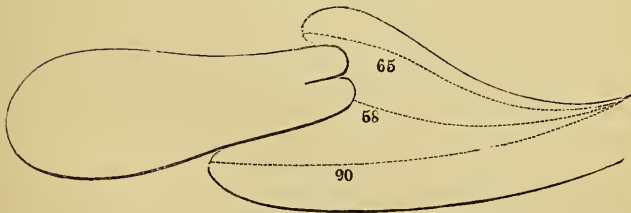
† Aran, *loc. cit.*, p. 1018.

delivered naturally of her first child about a year after, and from that time she has seldom been free from lumbar and pelvic pains of a bearing-down character. Menstruation has since been much freer, and there has been a good deal of leucorrhœa in the intervals. On examination, the cervix was directed forwards and upwards towards the pubis, about two inches from the vaginal orifice; the anterior cul-de-sac was deep and free; the posterior deep, about 82 millimetres from the orifice, and contained the retroverted fundus. The uterus was moveable, and could be easily replaced.

FIG. 16.



Upright posture.



Recumbent posture.

The figures refer to the distance in millimetres of the parts in question from the vaginal orifice.

Fig. 16 represents roughly the position and direction of the

uterus in the two postures, standing and lying—the figures refer to the distance from the vaginal orifice, measured in millimetres.* There were no evidences of any inflammation, or congestion. She was ordered a generally tonic plan of treatment, under which she improved; and, so long as she remained recumbent, there was little to complain of; but as soon as she resumed the upright position, the bearing-down pain came on.

A sponge was placed in the posterior cul-de-sac, and this gave her great relief, so that she could walk about with comparatively little discomfort; and she left the Hospital on the 28th of September.

In sixteen patients who had had one or more children, anteversion, with pelvi-peritonitis, or inflammation of the broad ligaments, existed. It has been said that the anteversion, in this class of cases, is due to adhesions;† but, though in one case I have traced out this occurrence, and in a second have found the uterus which, previous to the pelvi-peritonitis, was anteverted, after the attack, became fixed almost immoveably in an anteverted position, with an inclination to the right side; yet my observations are at present too few to settle this question. No doubt the co-existence of pelvi-peritonitis is of the greatest consequence; all the patients referred their sufferings to the peritoneal affection; or, at least, to an acute febrile attack, which followed labour. I lay the more stress upon this point, because it is passed over by those who attach what I believe is an undue importance to uterine “deviations,” and who consequently adopt very dangerous mechanical treatment. Thus, of the two cases recorded below;‡ in one they would see only a simple deviation,

* A millimetre is about equivalent to the 1-26th of an inch.—ED.

† Améline, *Essai sur l'anteversion de l'utérus (Thèse)*, Paris, 1827, No. 55.

‡ Obs. de M. Piachaud, *Thèse de Paris*, 1852, p. 63.

Abortion at the third month; fever and pain in the left side eleven days after; sacral and hypogastric pains since; second abortion at the sixth week; anteversion; treated by a hypogastric bandage and intra-uterine redresser.

J. A., aged 30 years, was admitted into *La Charité*, March 31st, 1851. She began to menstruate at 19, was married at 21, and had her first child at 22. She had her second child at 24, which was followed by some inflammatory attack. At 27, she had a miscarriage at the second month, which was also followed by symptoms of inflammation, for which leeches and blisters were applied to the iliac fossæ and lumbar regions. After the

and, in the other, an anteversion coupled with some metritis. Yet these patients never lost their pains and uterine distress; and one of them, after each pregnancy, had an inflammatory attack, which was no doubt a revival of the original pelvi-peritonitis.

In some cases the history of pelvi-peritonitis is, no doubt, very obscure; as when it occurs in that chronic form which we sometimes meet with in puerperal and scrofulous patients—but digital examination is diagnostic of this condition, and even where the peri-uterine tumefaction is “resolved,” we can generally recognise some adhesions by the tenseness and resistance in the vaginal culs-de-sac, by the sharp pain caused on moving the uterus, and more especially on trying to push it to the opposite side to that in which the peri-uterine swelling is situate.

The exploration must be conducted very gently, and with great care in the use of the “sound,” as peritonitis has often been the result of a want of caution in this respect.

In all the patients I have seen who had suffered from pelvi-peritonitis there was, besides the adhesions and uterine deviation, a copious catarrhal discharge, the organ was heavy and enlarged, and the cervix exhibited granular or fungous ulcerations. The amount of mobility does not seem to be of much consequence, and the belt or sponge pessaries will, in some cases, give relief; for in one patient, the uterus was very mobile, yet there was no pain or distress as a constant symptom; but only at every menstrual period colic and

abortion she was subject to constipation and leucorrhœa. A year afterwards, M. Robert recognised the existence of uterine deviation, for which a bandage was applied, the uterus being anteverted; but, after using this for a considerable time, very little, if any, benefit appears to have resulted. She subsequently came under the care of M. Valleix, who used a uterine redresser, and in a short time the displacement was perfectly cured, but she still suffered a good deal from pelvic pains.

Obs. de Valleix, (*Leçons sur les déviations utérines*, 1852, p. 54).

M. S., aged 28 years, aborted at the third month, in her seventeenth year, after which she had four natural deliveries at term, but all were followed by attacks of inflammation. For the last six months she has been subject to metrorrhagia. On admission at the *Hôpital Beaujon*, October 16th, 1851, she had anteversion, with some slight left lateral deviation. The uterine redresser was applied; but, on account of hæmorrhage, which seemed rather to be provoked by it, it was obliged to be withdrawn and re-introduced several times. The patient, however, ultimately got quite well of the deviation, though she was never entirely free of pain.

sharp pains would come on in the left iliac fossa; and, as this had been the seat of the peri-uterine swelling, these symptoms were evidently due to some lesion of the tubo-ovarian organs, and not to the anteversion.

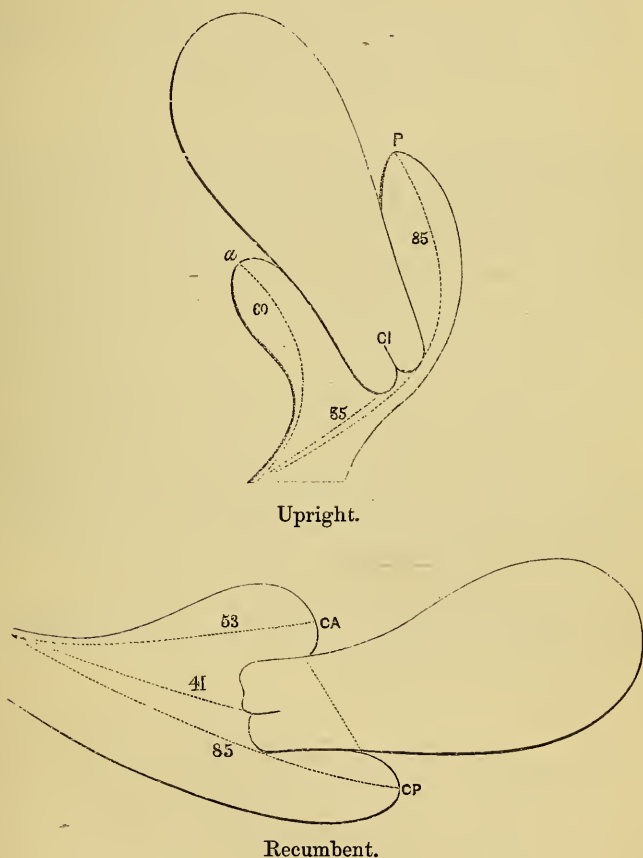
The only case in which the pains ceased was one where the uterus became normal in size, the cervix small, and of a pale rose colour, and free from ulceration, and the muco-purulent catarrh ceased; a proof that the functional disturbance was caused by the congestion, and chronic inflammatory condition of the uterus or its appendages. The amount of pain and of functional disturbance which, in some patients reappears immediately on their leaving their bed, while, in others, it comes on only after fatigue, the constant dull aching pain which increases at the menstrual periods, and is relieved by the discharge—all these are in exact accordance with the severity of the chronic mischief, and with the character of the exacerbations of the original pelvi-peritonitis. We must, of course, take account of the general health of the patient, especially if she be chlorotic or hysterical. In two cases where the hypertrophied ulcerated cervix, and the enlarged anteverted uterus partly fixed by old peritoneal adhesions amply accounted for the symptoms, they were greatly aggravated by hysterical fits, though in what way this is to be explained is not very clear. The following case will show the importance of studying the antecedent circumstances, and the part played by an old pelvi-peritonitis.

CASE IV.—*History of previous bad health; hysteria; pregnancy at the fourteenth year; delivery at the eighth month, followed by pelvic and uterine pains for five months; subsequent history of hysteria, and epilepsy.*

V. E., aged 60 years, admitted into *La Pitié*, January 26th, 1861. When 13 years old, she became subject to nervous attacks of an hysterical character, which were first brought on through mental emotion. Menstruation began at 13½ years, and she became pregnant six months after; labour came on at the eighth month, and was followed by an inflammatory attack, which kept her confined to bed for several months, after which she was admitted into the *Hôpital Beaujon*, where she remained for a month. In November, 1860, she married, and this seemed to aggravate, both in severity and frequency, the hysterical attacks; she was accordingly admitted into the *Hôpital St. Antoine*, December, 1860, and was treated as a case

of pelvi-peritonitis; leeches were applied to the left side, to a peri-uterine swelling there; and, in three weeks, she left the Hospital of her own accord. The pains returned again, and she was admitted into *La Pitié*, January 26th, 1861. On examination, in the upright and recumbent postures, the uterus was found to occupy the positions presented in these sketches, Fig. 17 (the figures give the distances in

FIG. 17.



millimetres from the vaginal orifice to the parts indicated). The vagina and cervix were normal. She was ordered hot baths, Vichy water, ether and opium.

During the month of February, the attacks of hysteria were, for

some reason or other, more than usually severe, and the abdominal and pelvic pains also increased. A variety of anti-hysterical remedies were administered with little or no benefit, and only when a state of semi-narcotism was induced, and all local treatment was discontinued, did the attacks appear to abate. She left the Hospital towards the end of March, and for some time she continued to improve, but in August she again became very bad with fits of an epileptiform character, but there were no special uterine symptoms. On examination, the uterus was found to be very moveable and markedly anteverted; a small, hard, kidney-shaped tumour existed in the left cul-de-sac, which was extremely tender to the touch.

We notice in this case—first, that the uterine pains and the hysterical phenomena disappeared together; secondly, that the hysteria diminished when we avoided irritating the genital organs by examination; and, thirdly, that the pelvic distress disappeared without any marked change in the local conditions. The case is very similar to those recorded by M. Marotte,* in which urinary disturbance depended on neuralgic or hysterical pain, and ceased with it. Indeed, in these cases, the local lesion seems to act very much as dental caries does, setting up a neuralgia in the neighbourhood of the disease.

To sum up then; it appears that marked anteversion may exist without any morbid symptom; that when uterine distress accompanies the deviation, the real cause of the suffering is congestion; and, lastly, that hysteria may aggravate the disease and the difficulty, though the lesion be but slight.

* Marotte, *De quelques épiphénomènes des neuralgies lombo-sacrées pouvant simuler des affections idiopathiques de l'utérus et de ses annexes* (*Archives de médecine*, avril 1860, p. 385 et 552).

CHAPTER III.

RETROVERSION.

“SIMPLE” retroversion, whether in nulliparæ or multiparæ, is so rare, that it may be said to exist only as a symptom of some other condition. Thus, in one hundred and fifteen nulliparæ at the *Lourcine* Hospital, I found only three cases with this displacement. In one, a polypus had caused hypertrophy of the uterus, and in the other two adhesions existed, the result of retro-uterine pelvi-peritonitis. M. Valleix’s testimony is to the same effect. Of course I do not here include that condition of the uterus where it becomes anteverted in the erect, and retroverted in the recumbent posture; and I mention this only to insist on the necessity of examining patients in both postures.

Case II. in the preceding memoir exhibits well the mode in which retroversion takes place, and is maintained. Valleix has noticed its occurrence after labour, and especially after any over-fatigue, and where we have that condition which Chomel calls post-puerperal metritis. M. Martin le Jeune relates a case,* where retroversion after labour seems to have been a recurrence of what happened to the pregnant uterus; and he records another case,† where it seemed

* Obs. de Martin le Jeune (*Mémoires de médecine et de chirurgie pratique*. Paris, 1835, obs. iv., p. 146).

I was asked in 1800 to see a woman who, after a fall, was suffering from retention of urine. She was pregnant at the time, at about the third month. I found, on examination, that the uterus was retroverted; and, without much difficulty, I reduced it with the finger in the vagina; but, on her getting up, the displacement was repeated, and again replaced. She went to full time and was delivered. Two years afterwards, I found there was still a tendency to retroversion.

† Obs. de Martin le Jeune (*Ibid*, obs. xv., p. 166).

Madame V., aged 30, began to suffer from prolapsus, after the birth of her fourth child, for which I ordered her a gimblet-shaped pessary. This gave

to follow the using of a globe pessary for prolapsus. It was reduced by means of a wooden spatula passed into the rectum.

The symptoms in all the patients were—leucorrhœa, frequent desire to micturate, obstinate constipation, and often sharp pain on defœcation, especially if the pelvi-peritonitis was not completely resolved; walking caused pain in the back, a sensation of dragging at the sacrum and groins, and especially of a heavy weight at the sacrum. The only case in which these pains disappeared, was where the other symptoms of catarrh and congestion of the uterus ceased.

Retroversion, when uncomplicated, gives rise to neither pain nor any other symptom. It usually occurs after a confinement, and there is almost always some falling of the womb.

relief for some time, when the womb became retroverted, and it was found impossible to replace it by the taxis. After some difficulty, however, I succeeded in replacing it, and she soon became pregnant, and went to the full time.

CHAPTER IV.

LATERO-VERSIONS AND LATERO-FLEXIONS.

LATERAL deviations of the uterus are called latero-versions or “obliquities.” The body may be inclined to one side and the cervix to the opposite; or the body may be inclined, and the cervix remain in the mesian line. We call it “right” or “left” latero-version, according to the inclination of the body. Sometimes the uterus is twisted on its axis; and I have met with a case where the os was vertical instead of transverse, where it was difficult to tell which was the anterior, and which the posterior surface of the uterus. Sometimes the body is twisted, while the cervix remains normal, so that the body has a slight lateral flexion on the cervix. Latero-versions and flexions have so many points in common, that we may discuss them together.

Latero-version is the most frequent form of deviation—Hippocrates* and Moschion† speak of it. I found it in sixty-two women out of two hundred and twenty-nine. It is usually complicated with some other form of flexure or version (*e.g.*, ante or retro), and often follows pelvi-peritonitis;‡ so that, out of sixty-two cases, I only found seven simple. On examining, at the *Maternité*, the bodies of female infants, still-born or dead within the first fortnight, I found:—

| | |
|---|----|
| Latero-versions or -flexions to the right | 11 |
| Latero-versions or -flexions to the left | 8 |
| Double latero-flexions | 3 |
| Retro-flexions | 2 |
| Uterus straight | 1 |
| | 25 |

* Hippocrates, (*Traduction de Littré*, t. vii., p. 385).

† Moschion (*De mulierum passionibus liber*, Traduction latine de O. Dewez. Vienne, 1793, caput xli., p. 200).

‡ Becquerel, *Traité des maladies de l'utérus*.

In all these, M. Lorain proved that the round and ovarian ligaments,* were shorter on the side of the uterine inclination than on the opposite. This arrest of development and diminished length may ultimately make a drag upon the uterus, but it is a result of the deviation of that organ, determined by the position of the rectum, and distension of the sigmoid flexure with meconium. M. Lorain showed that, in the eleven right latero-versions, the rectum was to the left of the mesian line; in the eight left latero-versions, the rectum was five times on the right; and, in three of these, the right border of the uterus presented a concavity moulded on the distended rectum; while in the two cases where the rectum was still on the left, the sinistro-version seemed due, partly to pressure of the sigmoid flexure, and partly to the difference in the points of emergence of the umbilical arteries, which turned the face of the uterus to the side opposite to the latero-version. The three double flexions were due to the double pressure exercised on one side by the rectum, on the other by the sigmoid flexure. These deviations remained when the intestines were taken away; the ligaments of the one side being stretched, while the opposite ones relaxed, when the uterus was thrust into the mesian line.

A good number, then, of the lateral deviations are congenital; but as development goes on, these diminish, so that only a few are found at puberty. M. Aran has rightly remarked that there is no preference as to right or left latero-version. In eleven out of fifteen, the uterus was otherwise normal; but in the other cases there was a second deviation.

The cases of simple latero-version were unaccompanied by any painful symptom, and were only discovered by digital examination. The deviations remained the same, both in the recumbent and erect postures, and did not influence the depths of the vaginal culs-de-sac.

Pelvi-peritonitis often produces latero-version. Some of the cases may, perhaps, have been congenital; but, in others, the peri-uterine tumour, by its pressure, either on the body or the cervix, is the mechanical cause: and a few result from adhesions between the uterus and the neighbouring organs.

The pains which the patients suffer, depend on the pelvi-peritonitis;

* Aran (*Archives générales de médecine*, 1858, 5^e série, t. ii., p. 321) refers the first study of this point to Tiedemann, and so does M. Piachaud, (*Thèse*, Paris, 1852, No. 76, p. 79).

and the side in which the tumour existed, often becomes, after its dispersion, the seat of dragging sensations. The fundus uteri is generally on the same side as the swelling; and thus we can account for Valleix's * remark, "that the pain is predominant in one groin only." We know, however, of five cases where the deviation and adhesions existed, and there was no pain or functional distress.

As latero-version in nulliparæ, is usually the pathological expression of pelvi-peritonitis or abscess of the broad ligament, so in the uni- or multi-paræ, it is the physiological expression of pregnancy and its results. In all the multiparous cases but one, the inclination of the uterus was towards the right; in one of these the cervix adhered to the wall of the vagina, after a chronic eczematous attack of vaginitis; in three, the left commissure of the os was split during labour, and became adherent to the vagina. It is just possible that there may be some relation between this right version and the fact of its congenital prevalence; and also the frequency of the preferential development of the right half of the uterus in pregnancy, and of the presentation of the head in the first position (*occipito iliaque gauche*).

The diagnosis of the position of the uterus is readily made out by digital examination, but the use of the sound is quite unjustifiable. We run great risk by its use of setting up peritonitis, and can gain nothing by it; for the redressing the uterus is impossible in these cases, where old abscess of the broad ligament has ended in fibrous induration of its cellular tissue, † or where there are peritoneal adhesions; and it is useless in simple latero-version, which causes no functional disturbance. Morbid symptoms remaining or appearing after the pelvi-peritonitis is cured, are due to chronic metritis; this is shown by the hypertrophy of the uterus, the ulceration of the cervix, and by the presence of muco-purulent uterine catarrh.

In the case quoted below, ‡ of blenorrhagic metritis, the symptoms were clearly due to the acute inflammation, and not to the latero-version, which existed both before and after the attack.

* Valleix, *Des déviations utérines*, 1852, publication de l'Union médicale, p. 143.

† West, *Diseases of Women*, p. 428, Third Edition, 1864.

‡ CASE.—*Menstruation at 11½; three pregnancies followed by abortion; peri-uterine inflammation, probably after the first abortion; vaginitis; two years after, fresh vaginitis; blenorrhagic metritis; right latero-version; cure; latero-version persistent.*

L. H., aged 23, was admitted into *Lourcine*, May 8th, 1855. She began

To sum up, then, latero-versions and latero-flexions, which are very common in the fœtus, are determined by the different positions of the rectum and sigmoid flexure, also by the varying origin of the umbilical arteries, which causes a difference in the length of the broad, utero-ovarian, and utero-sacral ligaments, and then the inclination is permanent. The lateral deviations diminish as development progresses, but pregnancy or adhesions of the cervix may give rise to new deviations. Latero-versions and latero-flexions do not cause distress, but are simply an irregularity of conformation. Functional disturbance only exists when there is some inflammatory or congestive condition of the uterus, of its appendages, or of the enveloping peritoneum.

to menstruate at 11½; was pregnant, for the first time, at 19, and aborted at the sixth month; was again pregnant at 21, and aborted at the third month. Six weeks after, she became pregnant again, and aborted at the middle of the third month; then an attack of vaginitis came on. In the following April, she had an attack of acute inflammation of the uterus. On examination, the uterus was carried backwards, and a good deal to the left; so that the os looked towards the left vaginal wall. The left vaginal cul-de-sac was, in consequence, very small; the right enlarged, and contained the fundus uteri, which was also enlarged and very tender. The anterior and posterior culs-de-sac were normal. Twenty leeches were ordered to the right groin; rest, and poultices. This treatment gave great relief; the pain and tenderness almost disappeared. She gradually recovered, and left the Hospital; prior to which, on examination, I demonstrated that the cervix was still turned to the left; the body of the uterus was situate transversely, the right border being in the right lateral cul-de-sac; the cervix could easily be pushed to its normal place, but it at once resumed its old position. The displacement gave no inconvenience. She left the Hospital at the end of May, quite cured of the metritis.

CHAPTER V.

ANTEFLEXION.

WHEN the canal of the uterus, instead of forming a straight line with that of the cervix, forms an angle at their point of junction, flexion is said to exist. The body may be flexed forwards, anteflexion—or backwards, retroflexion—the cervix maintaining its normal direction. In a few women, we find the body remains normal, while the cervix is bent either forwards or backwards in a horse-shoe shape.* This error of conformation is very rare, and entails no functional distress; but it almost always causes sterility.

True anteflexion and retroflexion, when simple, M. Paul Dubois† has shown to be unaccompanied by any functional disturbance; except, he adds, at the menstrual periods. Now, MM. Boullard and Verneuil have shown that anteflexion is the normal form, prior to impregnation; and, therefore, according to Dubois' theory, almost every girl ought to suffer from dysmenorrhœa. Instead, however, of theorising, let us examine the question fairly, both as regards women who have, and women who have not, been pregnant. In one hundred and fifteen nulliparæ, forty-one, (34·78 per cent), presented anteflexion; of these, nineteen were suffering, or had suffered, from pelvi-peritonitis; and in twenty-two, (19·13 per cent), the uterus was anteflexed, but not otherwise affected; they having entered the Hospital for vaginitis or syphilis; but of the whole forty-one, only five had suffered from dysmenorrhœa, previous to the pelvi-peritonitis. The first was 20 years of age; her menses appeared at the age of 18, and only four times afterwards. She suffered from weight and pains in the pelvis; but these were lessened when the

* *Bulletin de la société anatomique*, année 1856, p. 403.

† Paul Dubois, *Bulletin de l'académie de médecine*, décembre, 1849, p. 220.

discharge appeared ; they were, therefore, due to uterine congestion, and were not occasioned by any contraction at the os internum cervicis caused by the flexion.

In the second, the catamenia were regular and painless from the age of 11 to 19, when they were suddenly checked by cold ; they reappeared after six weeks' interval ; but were black, clotted, and accompanied with pain in the lower belly and loins, and with colic ; since then, the same distress has always occurred at the beginning of each period.

In two others, the menses were at first without pain ; but, after contracting gonorrhœa, the patients suffered from uterine catarrh, and at each period, uterine colic, one of them also passing small coagula.

In these cases, we see that anteflexion of itself did not interfere with menstrual excretion ; still I do not altogether deny its influence, for, in Case XVI., p. 64, there were lumbar pains and uterine colic, though there was no leucorrhœa nor uterine disease, but then sexual intercourse had repeatedly taken place previously to the first menstruation.

The twenty-two patients above-named had none of the symptoms commonly attributed to flexions of the uterus ; for I do not consider the leucorrhœa or slight uterine catarrh which most of the *Lourcine* patients present of any importance.

The only sign, then, of anteflexion is the physical one found by digital examination. The cervix is usually small and slightly elongated. In the anterior cul-de-sac, the finger traces a rounded tumour, continuous with the lateral borders of the cervix, and enters a sulcus at the point of junction. The posterior cul-de-sac is less resistant ; and the posterior surface of the uterus is less easily explored above the angle of flexion, than when it is straight or slightly anteverted.

We can often feel the fundus by hypogastric palpation, except in young girls whose abdominal and vaginal parietes are very firm. We ought indeed to content ourselves with this means of diagnosis ; for the uterine sound is not admissible, because it is dangerous, and in marked cases can only reduce the curvature for the moment.

The cervix, instead of remaining *in situ*, may be curved backwards, and then we have anteversion in addition to flexion. This condition we have found in seven out of nineteen cases. So, on the other hand the cervix may be, but very rarely is, carried forwards ; while the body, though flexed, is almost in the normal position ; here we have retroversion with anteflexion. I have met with this condition of things

in two out of nineteen patients, and in both the cervix was very long,* though not greatly hypertrophied.

In all the "simple" cases, the uterus was very mobile, not enlarged, and there was no functional distress; but a great difference exists among those who have suffered from pelvi-peritonitis. Of nineteen such patients, nine were under observation prior to this incident.

Case XIV., p. 59, is of peculiar interest, because, before her admission, there was no flexion; and its formation was witnessed during the progress of the pelvi-peritonitis, which was set up by the extension of the blenorragia to the uterus and Fallopian tubes. In the cases XVII. p. 67, and XVIII. p. 72, the flexion, originally slight, was increased by the pelvi-peritonitis. We see, then, that flexions are congenital in some cases, while in others they are acquired; and in these three cases, congestion, by augmenting the volume of the uterus, caused or increased the anteflexion, just as happens when we inject that organ. We see also that Virchow's theory, "that flexions are induced by the bands of adhesion, resulting from peritonitis, contracting as they become organised," is not here applicable; indeed, I have always found version rather than flexion in cases of adherent peritoneum; nor is it easy to understand how flexion can be thus induced in nulliparæ, as either the cervix must be fixed, or the uterine wall weakened at the angle of flexion.

The frequent coincidence of flexions and adhesions rather points to the liability to peritonitis in these women. And in the cases I have watched, the flexion generally comes on in the acute stage, and not during that of resolution, when the adhesions are said to contract. I believe, however, that their general tendency is rather to elongate than to contract. Whatever be the origin, all those patients who have suffered from pelvi-peritonitis, present the very symptoms which have been attributed to simple flexion. Thus, six out of the nine suffered at the menstrual periods with pains in the back, and expulsive uterine colic, especially when there were clots; all experienced pains in the lower belly; weight and discomfort greatly increased on walking or standing; and, it seemed to me, that these pains and dragging sensations were chiefly located on the side where the pelvi-peritonitis had been. For example, the patient who had had a right lateral tumour, suffered from dragging in the right groin; while she who had had pelvi-peritonitis in the recto-uterine cul-de-sac, suffered pain and weight at the fundament. These

* See Case XVII. p. 67.

pains last for a long period. Three patients,* whom I saw six months and a year respectively after recovery, were even then complaining of distress; and the least fatigue renewed the pains in the parts which had been affected; while the leucorrhœa, which had never ceased, became copious if they happened to be ill-fed. The uterine colic and expulsive pains in one of them, in whom the anteflexion was acquired, were much alleviated by the sudden discharge of a mass of uterine mucus; and I felt the uterus hard and globular during the crisis. These incidents are analogous to those observed in cases of flexion, when the cavity is dilated, and the cervical canal closed, either by contraction of the os internum or by the viscid mucus, which hinders the discharge from, and so causes an accumulation in, the uterine cavity.

Of the ten patients who were seen only when the pelvi-peritonitis had commenced, seven, after recovery, experienced dysmenorrhœa and lumbar pains; five had also expulsive pains during the first two days of the menses; all suffered from leucorrhœa, weight, and "bearing-down;" one of them from frequent desire to micturate (and here the peri-uterine tumour had occupied the anterior, posterior, and left sides of the uterus); and in all, the distress was most marked in the region where the pelvi-peritonitis had been situate. The usual catarrh and hypertrophy of the uterus were present.

The chronic distress is, then, clearly referable to the results of inflammation, and not to the anteflexion. The frequency of dysmenorrhœa in these women far exceeds that when there is no flexion; hence it follows, that simple flexion does not hinder the menstrual excretion, except when it is complicated with affections of the cervico-uterine mucous membrane. Rejecting, then, the purely mechanical theory of constriction, I regard the swollen condition of the mucous membrane and its diseases as of great importance.

Dysmenorrhœa is an obstacle to the recovery from pelvi-peritonitis, and it is probable that anteflexion, when complicated with disease of the cervico-uterine mucous membrane, predisposes to both menstrual and blenorrhagic pelvi-peritonitis.

Anteflexion in women who have been pregnant.

The influence of early conception, abortion, absence of milk, &c., on anteflexion, has been greatly aggravated. Instead of regarding pregnancy and labour as causes, I would say that they do not always

* See Cases XII. p. 52; XIV. p. 59; XVIII. p. 72.

modify pre-existing anteflexion; for, in one hundred and ten women who had had children, there were only nineteen cases of anteflexion; and of these, thirteen had suffered either from pelvi-peritonitis, or abscess in the broad ligament. Anteflexion, however, often recurs after labour.

Of the nineteen cases, the six with "simple" anteflexion exhibited no functional disturbance attributable to it. In one case only was there tenderness at the anterior wall of the uterus, while uterine colic and lumbar pains were present at each menstrual epoch; and a glary discharge escaped during the interval. The uterus in this case was large, doughy, and subinvoluted; the sound entered easily up to three inches; the cervix was ulcerated, and a good deal of viscid mucus flowed from it. This was, then, a case of post-puerperal metritis. Another of the six, though free from dysmenorrhœa, had copious leucorrhœa, evidently of a strumous character; the erect posture, though it increased the anteversion, just as in the nulliparæ, caused no suffering in these women; while in those who had had pelvi-peritonitis or abscess of the broad ligaments, standing or walking augmented the chronic distress.

It is very doubtful whether the anteflexion in the thirteen patients was acquired; three had had dysmenorrhœa from their first catamenia; of these, two suffered from leucorrhœa for two years; and one from an attack of vaginitis, followed by uterine catarrh, three years previously. In two other women, leucorrhœa appeared at one and two years respectively after menstruation; and, with it, dysmenorrhœa, the result of bad living. In these five patients, the antecedent dysmenorrhœa, with disease of the cervico-uterine mucous membrane, leads us to infer anteflexion.

In the remaining eight—three had no dysmenorrhœa at all, and in five it came on only after inflammation.

Whether or not flexion existed, it is certain that the distress complained of only began after the inflammatory attacks.

The thirteen patients may be thus classed:

- | | |
|---|--|
| 3 | when seen, had acute pelvi-peritonitis, |
| 1 | ,, chronic ,, |
| 1 | ,, abscess of the broad ligament, |
| 2 | had dysmenorrhœa which appeared after vaginitis, |
| 6 | ,, ,, ,, parturition. |

Of the last six :

| | | |
|------|---|--|
| In 2 | labour was terminated by forceps, | } antiphlogistic treatment being necessary after the births. |
| 1 | „ twin | |
| 2 | labour was followed by abscess of the broad ligament, | |
| 1 | „ peri-uterine tumour, the result of | |
| — | latent pelvi-peritonitis. | |
| 6 | . | |

I have insisted upon these details, because, from the neglect of antecedent inflammatory history, an undue importance has been given to flexions and versions; and it has not been seen that these displacements are merely phenomena, superadded to symptoms which have often been passed over, as they were in the case below.*

We will now examine the patients as they presented themselves, with only a few indistinct signs of past inflammation, but with ante flexion.

In eight, the ante flexion was marked, the uterus was large, the cervix also large, and generally showed some superficial erosion; in two, the granulations were fungoid; uterine catarrh being present in all.

The uterus was high, but usually either inclined to, or wholly lying on, one side of the mesian line, and there held by bands of peritoneal adhesions. In two patients it was fixed by old induration of the broad ligament; similarly to the cases quoted by West. These adhesions were less perceptible in some than in others; but in all, though the uterus was moveable in an upward direction, any attempt to thrust it laterally to the opposite side, which may be readily done in “simple” flexions, caused such pain as to forbid its repetition. Moreover, the erect posture did not modify the deviation, as is notably the case where there has not been any pelvi-peritonitis.

* Obs. *Extrait de la Thèse de M. le docteur Piachaud*, Paris, 1852, p. 74. (Obs. vi.)

L. L., aged 23, was admitted into *La Charité*, May 19th, 1851. At 17 she had her first child, the labour being accompanied by convulsions, and followed by an attack of pelvic inflammation. After her recovery, she suffered a good deal from pains about the pelvis, thighs, and back, with frequent desire to pass water, and constipation. On examination, the cervix was found to be normal in size and position; a small, hard, regular, and not painful tumour was felt in the anterior cul-de-sac, continuous with the cervix. It proved to be the ante flexed fundus uteri.

The following case exhibits well the result of peritoneal adhesions, and the principal symptoms in cases of anteflexion with old pelvi-peritonitis.

CASE V.—*Chlorosis ; vaginitis ; painful menstruation ; pregnancy ; abortion at third month ; pelvic pains ; chancres ; ulceration of the cervix ; anteflexion and latero-version.*

F. B., aged 21 years, was admitted into *Lourcine*, February 19th, 1856. At 15, symptoms of chlorosis came on with the commencement of menstruation, but no discharge appeared till she was 19½ years old, when it came on very freely with some dysmenorrhœa. She became pregnant soon after, and aborted at the third month. After this, she experienced a good deal of dragging pain in and about the pelvis, which was sometimes very severe, especially after walking, and was accompanied by febrile disturbance. Then she contracted syphilis, which affected her constitution, and for which she was treated with the iodide of mercury. On examination, the cervix was found towards the right side, and the fundus flexed forwards ; moreover, the right cul-de-sac was less deep than the left, harder, and more resisting ; the corresponding border of the uterus could be felt less on that than the other side, and it was also more tender on pressure there. Under the influence of mercury, she soon got quite well ; but the uterus remained fixed in its abnormal position.

There is no doubt that in this case flexion existed prior to the abortion ; for dysmenorrhœa, characteristic of disease of the mucous membrane, when combined with flexion of the uterus, began with the first menstruation, and vaginitis had occurred before that epoch. The vaginal exploration demonstrated the existence of adhesions, fixing the uterus on the right side ; and these were, no doubt, the result of *post-partum* pelvi-peritonitis. The dragging sensations in the loins and iliac fossæ, so constant on walking or standing, are explained by the inability of the uterus to yield to the pressure of the viscera, as the patient changed her position. These pains too, were augmented at the periodical congestion of the uterus.

In this, and similar cases, the uterus, though fixed, preserved its normal situation and relations ; but, in the following case, the uterus, though normal in the recumbent posture, fell forwards and downwards, pressing upon the bladder, when the patient was in a standing position.

CASE VI.—*Scrofula; menstruation at 17; pregnancy at 22; abortion at the third month, followed by some abdominal pain; dysmenorrhœa; syphilis; mercurial salivation; phthisis; ante-flexion; relieved.*

J. T., aged 24, was admitted into *Lourcine* under the care of M. Bernutz, April 10th, 1855. Early in life she showed symptoms of scrofulous disease. She began to menstruate at 17, but without pain, until after she had had sexual intercourse. In 1853 she aborted at the third month; and, being in service at the time, she took no care of herself, and did her utmost to keep it secret. After this she suffered a good deal from bearing-down pain, and menstruation became very painful; she contracted syphilis about a year after, and was treated with mercury to salivation. This weakened her a good deal, and she began to get symptoms of pulmonary phthisis. On examination in the recumbent position, the uterus was perfectly normal, but in the erect posture, though the cervix occupied its normal situation, the uterus was anteflexed. Constipation and frequent desire to pass water, after which there was a feeling of weight over the pubis. The mouth was still sore from the mercury. Ordered, chlorate of potash mixture; honey and alum gargle, and iodine inunction.

Under this treatment she gradually improved, but the following menstrual period was very painful, and the discharge scanty.

In May, the cervix occupied the same position, but the body of the uterus was larger and more tender; there was no swelling in either cul-de-sac.

At the following period menstruation did not come on, but there was a great deal of pain in both iliac fossæ; no tumefaction could, however, be felt anywhere; twelve leeches were applied to each iliac fossa; and, as they gave but little relief, a flying blister was ordered to the right iliac fossa. This was repeated in a few days, and the pain gradually subsided. The patient lost flesh and strength, and was more or less feverish. The vagina became hot; and both it and the uterus were tender, especially on pressing deeply in the culs-de-sac.

She left the Hospital on the 29th of June, the uterus still anteflexed, and a band of adhesion existed on the left side of the angle of flexion; the uterus was also much less moveable. The patient had lost all abdominal pain, and tenderness, and all sense of weight and bearing-down. She could also retain her water as long as she required.

Without stopping to examine minutely the syphilitic and phthisical symptoms exhibited by this patient or the passing febrile condition, which existed on April 26th, I would call attention to the diminished mobility of the uterus, which then succeeded, together with the apparent though not diagnostic signs, for no distinct per-uterine tumour was made out, of tubercular pelvi-peritonitis.

I may, by the way, notice the fact, that women, who have been suffering acutely, will often pass over slight pains or distress, which yet, their countenance shows, have become almost intolerable, and which compel them to seek further medical aid.

The subject of the last case complained, on admission, of bearing-down, dragging pains at the loins, and a sensation as of a weight falling forwards, when she passed water, symptoms which seem referable to mobility and anteflexion of the uterus; but the relief gained by rest showed that these were not sufficient causes, by themselves, to account for the phenomena in question. Increase of weight and size in the uterus, etc., due to congestion, are required in addition. The band of adhesion between the body and neck of the uterus, seems to favour Virchow's theory of the cause of anteflexion; but I cannot, without stronger proof, admit that it is any more than an hypothesis.

Whether, then, in this case, the anteflexion was congenital or acquired, it is certain that the sufferings of the patient began subsequently to the abortion. Their existence, concomitantly with the fever, point to an attack of pelvi-peritonitis, of which the adhesion was the result. The inflammation occurring in the vesico-vaginal cul-de-sac probably gave rise to the urinary symptoms.

The revival of the pains after some fatigue, when at first they had disappeared by rest, is referable to the uterine congestion, and incomplete resolution of the pelvi-peritonitis. In some patients, when the pelvi-peritonitis has become chronic, and leucorrhœa and hypertrophy of the uterus still exist, the distress remains, but is alleviated by the abdominal belt or pessary, which restrain the excessive mobility of the uterus—a mobility, innocuous in itself, but a cause of suffering when the uterus is congested and enlarged. I conclude, then, that anteflexion, whether congenital or acquired, is, by itself, unimportant; but, when catarrh or other disease of the mucous membrane, or uterine congestion, is superadded, the special conformation of the cervico-uterine canal predisposes to obstructive dysmenorrhœa.

CHAPTER VI.

RETROFLEXION.

OF eighteen women who presented retroflexion of the uterus, eight had never been pregnant; and of these eight, in only one could the cause be assigned. Here, fracture of the pelvis from a fall, accompanied by metrorrhagia and displacement of the uterus, occurred at the age of 12. When this patient was admitted to the *Lourcine*, at the age of 27, the uterus was found to be fixed to the rectum and pelvic wall in retroflexion; yet she had never, since her fall, had any symptom referable to the displacement, except sterility.

From the frequency of retroflexion in nulliparæ, both in foetal and adult life, M. Verneuil believes it to be usually congenital.* The case just quoted shows that it may be traumatic; while the symptoms in the case of M. Valleix, though misread by him, were those of pelvi-peritonitis.

The patients with congenital retroflexion experience no uterine distress; and even where leucorrhœa exists, there is no dysmenorrhœa, as in ante flexion; probably because the angle of flexion in the former is less than in the latter.

* Obs. *Extrait des Leçons cliniques sur les déviations utérines de Valleix, rédigée par T. Gallard.* Paris, 1852, p. 122.

A young girl had been ailing for three years, when, on examination, it was found that her cervix uteri was looking backwards and downwards. The fundus was also posterior, and to the left. She had previously had an attack of inflammation, apparently in the left broad ligament, which, by undergoing subsequent contraction, had drawn the uterus down to that side. The tissues there were less supple than elsewhere. The passage of the uterine redresser gave such great pain, that the attempt to replace the uterus was abandoned. There was no flexion. After two months of treatment, great improvement resulted; the uterus assuming a perfectly normal position, which it afterwards maintained.

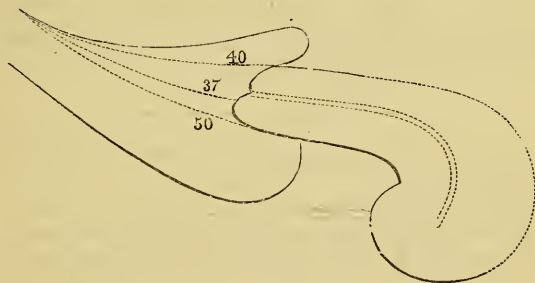
I will now detail a case, and then make some remarks on the points in which it differs from others.

CASE VII.—*Menstruation regular and painless, up to the age of 13½; leucorrhœa; blenorragia; retroflexion; cure of the blenorragia.*

M. P., aged 18, was admitted into *Lourcine*, February 19th, 1856. She began to menstruate at 13 without pain, and was afterwards quite regular. Had not been pregnant. For three weeks before admission, she had been suffering from blenorragia, which she had caught by sexual intercourse.

On admission, the vagina and cervix were very red. The cervix was directed forwards and upwards towards the pubis; the anterior cul-de-sac was free; the posterior was occupied by a globular, somewhat tender swelling, which proved to be the retroflexed fundus; the parts, indeed, were pretty much as is represented in this sketch, Fig. 18., they are shown in the recumbent position.

FIG. 18.



The sound passed easily up to the fundus; but any attempt at replacement gave pain, and the fundus seemed as if it were fixed in its abnormal position.

The blenorragia was speedily cured by the use of nitrate of silver lotion; but when she left the Hospital on the fifth of April, no change had taken place in the retroflexion. It did not, however, appear to occasion any inconvenience.

This case teaches us the important fact that, in the absence of symptoms, the retroflexion was only discovered by digital examination. The uterus, when this patient stood, became almost straight;

and in two other patients it descended, so that in one the distance from the vaginal orifice to the cervix, which in the recumbent posture was 47 millimetres (1·850 inch), in the erect was 28 millimetres (1·102 inch). The cervix in these cases is often elongated, either in the supra- or sub-vaginal portion; and, as Martin le Jeune * has observed, we must be on our guard against mistaking this condition for prolapsus of the womb.

Retroflexion in women who have had children is seldom "simple." I have met with only one case where there had never been any uterine symptoms. Here, perhaps, as in some cases of ante flexion, the uterus returned to its congenital condition of retroflexion after the confinement. In two women who had retroflexion before their pregnancy, at three months after labour I could find no flexion, nor even any depression at the point where the bend had formerly been.

We are as yet unable to determine the exact influence that pelvi-peritonitis has upon retroflexion; for, though this complication, or its results, was found in seven patients, we cannot positively assert that it was not pre-existent.

The uncertainty as to the effect of difficult parturition, causing and conjoined with pelvi-peritonitis, would have been equally great had I not accidentally met with the following case.

* *Obs. de Martin le Jeune, Mémoires de médecine et de chirurgie pratique.* Paris, 1835, obs. xxii. p. 174.

Madame D. had suffered for some time from retroversion; and, on attempting its reduction, it was found that this could only partially be accomplished. At first it was not easy to say why; but, on fuller examination, it was discovered that a tumour existed in the right iliac fossa, and had pushed down the fundus uteri, and prevented its replacement.

"In one particular form of retroversion, which I believe I was the first to notice, the os projecting beyond the vulva, and the fundus uteri being pushed against the sacrum, the cervix is curved like the neck of an ewer, and placed below and in front of the pubis, while the body of the organ is retained in the cavity of the sacrum, and approaches the perineum, as may be seen in Case X. of this memoir. This displacement, the mechanism of which is easily understood in those cases where the cervix is much elongated, may be confounded with prolapsus uteri, in which the os is retained within the vulva, either by its own inflammation, or by swelling of the soft parts around; but we may easily distinguish these two affections by comparing the symptoms peculiar to each, and especially by the position of the uterus itself."

CASE VIII.—*First menstruation at 13; first confinement at 19, followed by a good deal of pain; retro-uterine phlegmon, anteversion and slight prolapse, treated by leeches, and the application of Gariel's pessary.—Cure.—Chancre of the vulva; retroflexion; peritoneal adhesions round the uterus; syphilis, &c.*

H. R., aged 21, was admitted into *Lourcine*, January 30th, 1855. She began to menstruate at 13, and continued regular till she became pregnant at 18. The labour was natural; but, on the fifth day, she got up, and was seized after it with rather severe abdominal pain, especially on the left side; for a year after, she had constant leucorrhœal discharge; menstruation did not come on for six months, and then was very painful.

In May, 1854, she was admitted into *La Charité*, when a peri-uterine phlegmon was discovered, with some anteversion and slight prolapse. For this, leeches were applied, and one of Gariel's pessaries, and in two months she was quite well. In January of the following year she contracted syphilis. For this she came into *Lourcine*, and was cured under the influence of iodide of mercury. I then discovered, by examination, that the anterior and right lateral cul-de-sac were quite free; but the posterior was occupied by a round, firm, resisting tumour, separate from the cervix by a slight groove; it moved with the cervix, following the right border of the cervix into the right lateral cul-de-sac; it was noted that the tumour was continuous with the cervix; in the left cul-de-sac there was an indistinct oblong tumefaction sharply separate from the uterus. Pressure in the posterior and left cul-de-sac gave pain.

She was examined again at the end of April, when the parts were less tender, it was then proved that the body in the posterior cul-de-sac was the fundus uteri. There was no difficulty in micturition or defæcation. She left the Hospital on the 25th of May.

Here the change from anteversion to retroflexion was probably due to the combined effects of the pessary and the pelvi-peritoneal adhesions; and these latter alone were sufficient to cause it in a patient of M. Lailier.*

* CASE .—*Pelvi-peritonitis; general peritonitis; pleurisy; jaundice; retroflexion; death; autopsy. Pelvic abscess and adhesions among the pelvic*

Whatever may be the mechanical cause, it is certain that the acute pains which were felt during the phlegmon ceased afterwards; and that only bearing-down pains and tenderness on pressure remained, though the traces of old pelvi-peritonitis and hypertrophy of the uterus were manifest; and these symptoms disappeared after the attack of typhoid fever.

The uterine catarrh, which still persisted, was due to anæmic debility.

It is rarely that such complete relief is obtained; still I have met with one other patient, in whom I found retroflexion and descent of the womb, with old peritoneal adhesions, the result of *post-partum* inflammation four years previously, who was quite free from any discomfort. All the other patients were examined during the acute or sub-acute stages of inflammation; and they all exhibited the usual train of symptoms. At a later period, these greatly abated; but were more or less revived by a long walk.

Constipation is always marked; but the cause is not, as has been

organs.—Inflammation of the Fallopian tubes; internal metritis; varicose condition of the cervix.—Retroflexion due to the adhesive inflammation.

H. G., aged 23, was admitted under my care, March 3rd, 1862. Had a natural labour in 1861; and, a month afterwards, having over-exerted herself, she had an attack of pelvic inflammation. On admission, she had jaundice, and pleuritic inflammation. The uterus was retroflexed. The examination gave great pain, especially on pressing the left and posterior borders of the uterus. She got worse, and died on the 17th March.

On *post-mortem* examination, there was found pleurisy of the right side, and small hæmorrhagic spots in both lungs; and in the left a small tubercular cavity. General peritonitis; liver enlarged, pale, fatty, and friable. The pelvic viscera were adherent to one another. There was no pelvic cavity, except on the right side. On the left of the uterus was a tumour, which could not be discovered during life, as the retroflexed fundus interposed between it and the examining finger. In this tumour was a collection of thick pus, situated between the rectum and the uterine appendages of the left side, and covered over with false membranes. The tumour was formed of the tube, ovary, and thickened broad ligament. The Fallopian tube was thickened from inflammatory action; its mucous membrane very red. The same, though to a less degree, in the right tube. Both ovaries were congested. The uterus was reiroflexed at a right angle; false membranes uniting the fundus to the cervix and to the rectum; when these were divided, the uterus could easily be replaced, but not otherwise. The uterine tissue at the seat of flexure showed nothing abnormal. The uterine mucous membrane was thick, and very vascular. The vessels of the cervix were in a varicose condition. The cervix was ulcerated.

supposed, pressure of the fundus uteri, for there is none. It is due rather to a state of inaction of the rectum and sigmoid flexure through the peritoneal adhesions, which have formed between these organs and those of generation.*

In only two of the patients were the chronic pains such as to induce them to re-enter a hospital, and they were relieved by rest.

Uterine catarrh was present in all, and also hypertrophy of the uterus. This last is a proof that the pains and chronic symptoms are referable to disease set up by the peritonitis, and to the occurrence of congestion in the uterus.

Enough has now, I think, been said on the physical signs of retroflexion, complicated with old peritonitis. I will only add, that generally we find the uterus is but slightly moveable; and that examination causes pain, or, at least, an aching feeling, similar to that arising from fatigue. The uterus, also, falls lower than normal in the vagina, when the patient is erect. The sound, which ought seldom or never to be used, always passes with more or less difficulty through the os internum; and, in so doing, diminishes, if it does not remove, the flexion.

* Cossy, *Mémoire déjà cité*, t. iii., *Des Mémoires de la Société médicale d'observation*.

CHAPTER VII.

PROLAPSUS UTERI.

THE condition of the womb, when lower in the vagina than normal, in combination with flexions and versions, has already been amply noticed. I shall now, therefore, examine only that class where the cervix projects more or less outside the vulva. This admits of three sub-divisions: prolapsus without elongation of the cervix; prolapsus with hypertrophy of the sub-vaginal portion; and prolapsus with hypertrophy of the supra-vaginal portion of the cervix.

Prolapsus of the first kind is rarely produced suddenly, and then is almost always traumatic; a fall, etc., being the cause. There is pain at the time; and the prolapse once produced, tends to increase. It is usually met with in aged women;* and, on this account, does not give rise to further mischief than ulceration of the exposed surface by friction, and urinary distress from concomitant vesical displacement. Gradual prolapse is more common, and usually follows labour. Some patients experience no discomfort; others, again, suffer from pains in the back and groins; and in these cases the uterus is generally found to be sub-involuted.

Labour tends to produce prolapse mechanically by drawing on the suspensory ligaments, and distending the soft parts pathologically,

* Huguier, *Des allongements hypertrophiques du col de l'utérus*. Paris, 1860, p. 101.

Complete procidentia of the uterus, beginning at the age of 61, from violent exertion. Obliteration of the internal os.

M. J. C., aged 70, was admitted into *Lourcine*, 25th July, 1843. Had one child at 26. Menstruation ceased at 50. Ten or eleven years after that, while violently exerting herself, she felt something give way; severe pain followed; and that same day the uterus protruded from the vulva. The sound could not pass more than about one inch when she was admitted, the internal os being apparently closed.

by giving rise to chronic congestion and inflammation. Once the cervix reaches the vulva, the uterus descends more and more, until prolapsus is complete. Its course is accelerated by long-standing, by fatigue, by menstrual or other congestion of the uterus, by violent efforts, falls, by straining at stool, by cough, etc.

CASE IX.—*Complete procidentia of the uterus without allongement, and without any lesion of it or the surrounding parts.*

Mrs. C., aged 50, came under my care in 1854, for prolapsus uteri; and again for procidentia, on October 4th, 1858. She has been a washerwoman since she was 15 years old. Was always regular; the discharge abundant; more so about the time when the uterus first became prolapsed. Had had five children; labours all natural. Six weeks after her last, when 38 years of age, she first began to suffer bearing-down pains, and from that time to the present the womb had been down. When under my care in 1854, I applied a pessary of M. Hervez de Chégoïn, but it would not keep in.

The uterus, on admission, was procident, about the size of a lemon. The vagina was inverted; there was no ulceration; the sound passed two inches and a half; the uterus was slightly retroflexed.

Round the centre of the tumour there was more tenderness than elsewhere, and this was increased just before menstruation. All attempts at reduction at that time were painful; micturition and defæcation natural.

The uterus could be easily replaced when not menstruating, without causing any pain, but rather the reverse.

I need not dilate upon the well-known symptoms which are common to most, if not all, of these cases, the sensibility in the tumour, which is increased at the menstrual periods; the difficulty experienced in the acts of defæcation and micturition, while the frequency of the latter is often augmented to actual incontinence. One point is noteworthy, viz., that the peculiar feeling of distress, amounting sometimes to syncope, which is felt on exertion when the womb is quite outside, does not occur when it is only on a level with the vulva. The same symptom is seen in some large irreduced herniæ, and in cases of hæmorrhoidal tumours.

While incontinence of urine is often produced by the strain on the bladder, it sometimes happens that calculi form in the vesical pouch, which is never completely emptied.

CASE X.*—*Complete procidentia of the uterus.—Vesical calculi.—Urethro-vaginal cystotomy.*

M. L., aged 51, was admitted into *Hôtel Dieu*, 6th of March, 1842. Menstruation ceased two years ago. At 19 she had her first child; and, from that time, there have been symptoms of prolapse. Ten years ago, the uterus protruded from the vulva; since when there has been occasional difficulty of walking, and complete incontinence of urine.

On admission the tumour between the labia was the size of a foetal head, in the centre of which was the os uteri; the vagina was completely inverted, and the mucous membrane hard and thickened. On examining the bladder, several calculi were found in it, and they were prolapsed with the bladder on to the anterior surface of the uterus. The urine contained a good deal of pus. The calculi were removed on the 9th of March, and she gradually sank, and died on the 14th.

On *post-mortem* examination, seen from above, the uterus was found to be completely out of the pelvis, but its appendages were *in situ*; portions of intestine had slipped down into the lower pelvis. The bladder was also in part protruded. The peritoneum covering these parts was sub-acutely inflamed; the interior of the bladder contained a small quantity of pus.

We see by the *post-mortem* examination of this case, that, contrary to M. Huguier's† opinion, the cul-de-sac formed by the inverted vagina contained some intestinal convolutions.

The formation of calculi has been said by some to exist prior to, and to be the cause of the vesical displacement.‡ This is denied by others who think that the impediment to perfect evacuation of the bladder is the predisposing cause of the calculus.§ ||

Unfortunately, though many cases are on record, their history is

* *Bulletins de la Société anatomique*, année xvii. p. 149.

† Huguier, *op. cit.* p. 86.

‡ Ruysch, *obs. anat. chirurgie. Centuria.*

§ Gosselin, *Société anatomique*, année, 1842, p. 155.

|| *Bulletins, Société anatomique*, 1838, 13^e année, p. 304. M. Durand Fardel exhibited the genito-urinary organs of a woman aged 70. The uterus was procident, but of normal shape and size. The rectum natural.

so imperfect, that the question of causation is still unsettled; but, doubtless, both explanations are applicable to different cases respectively.

The amount of distress caused by even complete prolapse, varies a good deal in different persons; in some, as in the case recorded below,* it gives rise to very little inconvenience. As long as the prolapse is incomplete, the uterus usually goes up of itself when the patient lies down, and even when it is complete, reduction is generally easy, unless there is elongation of the cervix, when it often becomes difficult.

SECTION I.—PROLAPSUS UTERI, WITH ELONGATION OF THE SUB-VAGINAL PORTION OF THE CERVIX.

M. Huguier has divided elongation of the cervix into hypertrophy of the part above the insertion of the vagina, and that below. In both kinds the whole organ is enlarged; but it is classed under one or the other head, according to the portion chiefly involved, the physical signs and morbid symptoms being different.

In hypertrophy of the sub-vaginal portion of the cervix, the finger per vaginam meets it low down—perhaps at the vulva; and so the case might be mistaken for simple prolapse of the womb, but further examination proves that the vaginal culs-de-sac retain their normal dimensions. As I have already remarked, this form of displacement, which occurs more often among nulliparæ, gives rise, as a rule, to very little inconvenience. In one case recorded below,† a

The descent of the vagina dragged with it the bladder; and in the hernia so formed about 150 lithic acid calculi were found. The coats of the bladder were healthy.

* Case of prolapsus uteri with complete inversion of the vagina, by M. Pointe, physician to the *Lyons Hospital* (*Journal de médecine et de chirurgie*, t. lxxxv., p. 302, 1823).

J. B. had had, for the last thirty years, a large tumour protruding from the vulva. She died from an attack of diarrhoea. On *post-mortem* examination, the uterus and bladder were found quite out of the pelvic cavity externally; the tumour measured five inches by three. The inverted mucous membrane was hard and dry, and excoriated; and on section was nearly an inch in thickness. The uterus itself, though somewhat thickened, was otherwise healthy.

† T. A., aged 22, was admitted into *Lourcine*, January 30th, 1856. She had had a child five years before; the labour being followed by a smart

primipara, there was besides allongement, a transverse hypertrophy; and she suffered a good deal from sexual intercourse, which was generally followed by a slight discharge of blood. This condition I have met with chiefly in nulliparæ; and with M. Huguier, I believe that it occasions little or no functional distress, unless it is complicated with disease of the utero-tubal mucous membrane, or with pelvi-peritonitis, or with real prolapsus uteri.

Prolapsus uteri is a frequent consequence of this cervical hypertrophy; and, though at first slight, it speedily increases if the patient suffers from any bronchial or intestinal disturbance; any sudden and violent effort may bring the womb down at once. Distress is then felt when the woman sits down, or runs, or stoops forward suddenly. The catamenia become profuse, sometimes amounting to a flooding, and a copious glairy mucus is poured out from the cervical follicles.

There is often frequent desire to urinate, and the projecting cervix generally becomes sore.

CASE XI.—*Conical allongement of the subvaginal portion of the cervix mistaken for prolapse of the womb.*

A. P., aged 37, was admitted into *Lourcine*, March 12th, 1844. She had her first child twelve years ago, this was followed by an inflammatory attack; and six months afterwards, while lifting a heavy weight, something came down and protruded beyond the labia. Some years after she had her second child, all passing off well. She has consulted many physicians, and all have told her that she had falling of the womb.

On admission, she complained of a good deal of pain about the pelvis, but on examination it appeared that, though the cervix protruded beyond the vulva, the vaginal culs-de-sac were all entire, and the finger could pass all round the cervix. The sound gave the length of the uterus as about five inches; the fundus being in its normal position. The case was therefore one of hypertrophic allongement, and not of prolapse. She was ordered rest in bed, and emollient vaginal injections. These last were afterwards substituted for an

attack of inflammation somewhere in the left iliac fossa. For the last five or six months sexual intercourse had been painful, and followed by a sanguinous discharge. She contracted syphilis, and on examination, besides the chancres, the uterus was enlarged, and there was found a tumour attached to its left border.

astrigent injection, and some iodide of potassium was given; ergot of rye was subsequently added to the iodide. She left the hospital of her own accord shortly afterwards.

Here the only predisposing cause of the prolapsus uteri was the hypertrophy of the cervix.

In some women we find also a short vagina; such was the case in the patient whose history is recorded below;* who presented the same symptoms as in Case XI, with the addition of pain on coitus.

The frequency of concomitant uterine disease has been observed by Huguier and others. It is quite possible that there is a proclivity to cervical, and cervico-uterine catarrh. The length of the cervix may impede the natural mobility of the uterus, while prolapse may favour congestion and inflammation; for we find that women who have the cervix hypertrophied are peculiarly prone to pelvi-peritonitis and peri-uterine disease. The Cases II. to V., and IX. of M. Huguier, are proofs of this, and in his fifth Case detailed below,† no constitu-

* *Obs. de M. Vautrin (mémoire de M. Huguier, déjà cité, p. 40.)*

Case of hypertrophic allongement mistaken for prolapse, cured by amputation of the cervix.

M. E. B., aged 23, was admitted into *Saint Louis*, October 27th, 1854. One and a half years after she began to menstruate, at 13, a small nodule appeared at the vulvar orifice. This has remained very much the same to the present time. She has suffered a good deal with pain in the loins and hips, &c. She married at 21, and soon after she was told that she had falling of the womb. Sexual intercourse was painful; she has never been pregnant. On examination the uterus measured five and a quarter inches. The vagina, though somewhat shortened, was not at all everted, and the fundus uteri occupied its normal position. On the 15th November, M. Follin attempted to reduce the calibre of the vagina by means of Desgranges pincers introduced at different points round the vagina. This failed, and on the recommendation of M. Huguier, a portion of the cervix was excised on the 12th December. There was no hæmorrhage or any evil consequence, and she left the hospital cured, on the 4th January, 1855.

† Huguier, *mémoire sur les allongements hypertrophiques du col de l'utérus*. Paris, 1860, p. 34.

Hypertrophic allongement of the sub-vaginal portion of the cervix, especially of the anterior lip; excision of the cervix; cure.

A. P. D., aged 43, consulted me on the 17th November, 1850, for a prolapse of the uterus. She married at 22; but had for years before suffered from a sense of bearing down. Had her first child ten months after marriage; labour difficult; bearing-down pain arose after it. Her second child was born five years after. At 39, she had a severe attack of inflam-

tional disturbance arose, until an attack of pelvi-peritonitis complicated the hypertrophy, and greatly aggravated the symptoms, these being relieved by ablation of the cervix.

The excessive development of the anterior lip, follicles, and vessels of the cervix, and the absence of cystocele or other tumour, point to a congenital origin. M. Follin's case is similar. Hypertrophy of the cervix may be a consequence of pregnancy or labour; of deposit in the anterior labium; of the dragging down caused by recto- or cysto-cele.

In a case published by M. Herpin,* (of Geneva), the hypertrophy was developed during pregnancy. In the case given below,† of M. Huguier, it followed labour. The condition of the cervix, the appearance of its lining membrane, and of the granulations, together with the softness of the os, are very different to what we have hitherto spoken of. The "bearing down," the cessation of the menses during four months, succeeded by a flooding, and a subsequent unusual persistence of the flow, show that these lesions of nutrition are puerperal.

When the hypertrophy is confined to one lip, it usually affects the

mation in the pelvis. Suffered much afterwards from pains in the loins and thighs; leucorrhœa; sexual intercourse extremely painful; menorrhagia; difficult micturition and defœcation. On examination the cervix, or rather the anterior lip, protruded from the vulva about one and a half inches; it could easily be replaced. The sound penetrated three and a half inches to the internal os, and proved that the uterus was normally placed, except that it was somewhat depressed.

On the 28th November, a portion, nearly three inches of the cervix, was removed. There was nothing unusual about the operation, and the patient made a good recovery.

* *Gazette médicale de Paris*. Janvier, 1856.

† Case by M. Bonnemaïson. (Huguier, *op. cit.*, p. 37.)

Hypertrophic allongement of the sub-vaginal portion of the cervix; excision; cure.

M. J., aged 28 years, was admitted into the *Hôpital Beaujon*, May 17th, 1858. She married in 1856, and had her first child ten months after. Symptoms of prolapse came on a short time after that; suffered a good deal from leucorrhœa. On examination the cervix was found a good deal elongated, the two labia especially; the direction of the uterus was normal, hence no difficulty in micturition or defœcation. On the 26th May, amputation of the cervix was performed. The operation gave very little pain, and there was no bleeding. Some croton oil was rubbed into the thighs as a revulsive. There was no inflammation; and on the 11th June, she was discharged quite cured.

anterior, and is often consequent on some tumour, an enlarged follicle, or a fibroid.*

In the following case cystocele determined the hypertrophy of the cervix and the prolapse of the womb, though it is difficult to assign the exact share that each lesion had in the various complications of cystocele, ruptured perineum, enlarged uterus, multiple labours, old pelvi-peritonitis and menorrhagia.

CASE XII.—*Laceration of the perineum from the use of forceps in a fifth delivery; subacute peri-uterine phlegmasia; subsequent abortion; metrorrhagia; prolapsus; cystocele; improvement.*

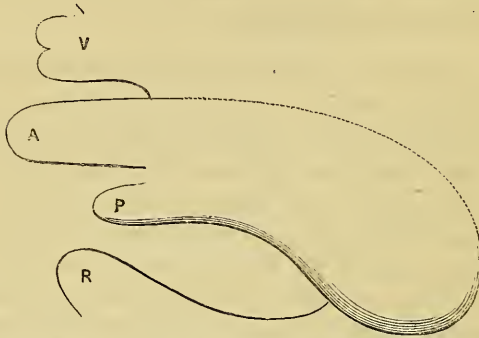
P. B., aged 44, was admitted into the *Hôpital Beaujon*, September 8th, 1858. She began to menstruate at 18, having previously had colicky pains in the abdomen. Her first pregnancy was at 25, and four others followed quickly, the labours being all natural except the last, which required the use of the forceps, and in which the perineum was ruptured. An inflammatory attack succeeded, from which, however, she got quite well, with the exception of being very weak, and subject to pains of a bearing-down character. For these she consulted M. Tardieu, who said there was prolapsus uteri. rest and poultices were ordered, and a ring pessary was applied; the latter, however, would not stay in. She became pregnant again and aborted at the third month. She was worse after this, and an abdominal belt was tried, which answered very well. For six years all went on well, she then had an attack of metrorrhagia, which was repeated again and again; and induced a very marked condition of anæmia. Three months after this the uterus appeared beyond the vulva. At first it only came down after exertion, and returned by rest. The abdominal pains, which during the metrorrhagia had disappeared, now returned, and she went into the Hospital on September 8th, 1858. She complained of colicky pains in the lower part of the stomach, but there was no difficulty in micturition or defæcation. About one inch and a-half from the vulva the elongated anterior lip of the cervix could be felt; the os was patulous and surrounded by granulations. In the posterior cul-de-sac was felt the retroflexed fundus uteri. The uterus was freely moveable. Ordered opium cataplasms and rest in bed.

* Huguier, *op. cit.* obs. iii., p. 30.

There was no prolapse while in the recumbent posture; but after being upright for a time, it came down just to the orifice.

On September 18th, the condition of the parts was pretty much as is here represented, the patient being in the recumbent posture.

FIG. 19.



v. Represents two folds of the vagina beneath the meatus urinarius. A. The anterior lip of uterus. P. The posterior. R. The posterior vaginal wall.

Fig. 19 v shows two large superposed vaginal folds just below the meatus urinarius; below this again was the prolapsed and hypertrophied anterior lip A, which projected beyond the vulva; then the os and posterior lip P. Behind this, in the posterior cul-de-sac, was the retroflexed fundus. When the patient strained the posterior

FIG. 20.



vaginal wall, r was projected beyond the vulva. The cervix presented somewhat the appearance shown in these drawings, Fig. 20.

The anterior lip was divided into three portions, of a violet colour, but not ulcerated. The sound gave the extreme length as three and three-quarter inches.

A caoutchouc pessary and a T bandage were applied; the former was reapplied each day. The patient left the Hospital on the 2nd October, much relieved; but the uterus still prolapsed, and resting on the pessary, which served very well to retain it within the vagina.

In this patient we see how very gradually the womb fell, only after heavy toil and persistent metrorrhagia. She suffered little during the floodings, but on their cessation pain was felt in the right iliac fossa (the seat of the old pelvi-peritonitis), and was again relieved by the hæmorrhage. Cazalis* compares this kind of prolapsus with what occurs in hæmorrhoids, when congestion keeps up constant tenesmus. The straining ends by eversion of the mucous membrane, as though it were the ejection of a foreign body.

The classification of elongations of the cervix aids us in the treatment and prognosis. When simply congenital it is innocuous; when combined with prolapsus uteri amputation may be required; when the result of cystocele palliative measures are often successful.

SECTION II.—ELONGATION OF THE SUPRA-VAGINAL PORTION OF THE CERVIX.

This condition, described by Morgagni † and Levret, ‡ has been the subject of special study by M. Huguier. § While, however, he describes at length the physical signs, diagnosis, and rules for resection, he has passed over the etiology.

From his monograph, childbearing would seem to be almost the only cause. He brings forward sixty-four cases, and of these, sixty were mothers, some of whom had had as many as ten or eleven children. As a rule, perhaps, the first time the hypertrophy is noticed is when the prolapsus uteri has occurred; hence, no conclusion can fairly be drawn as to the commencement of the elongation. We shall see, that the alleged influence of parturition ought to be

* Legendre, *Thèse de concours. De la chute de l'utérus.* Paris, 1860, p. 72.

† Morgagni, *lettre* xlv.

‡ Levret, *Journal de médecine, de chirurgie et de pharmacie*, par A. Roux, 1775, t. xl., p. 352.

§ Huguier, *Mémoire sur les allongements hypertrophiques du col de l'utérus.* Paris, 1860.

greatly restricted, when we examine the periods at which the cervix appeared at, or outside, the vulva. Thus in Case XVI. of M. Huguier,* and in that of M. Herpin† (of Geneva), it occurred during the pregnancy; while in Case XXXII.‡ it came on immediately after labour, in Case XIII.‡ some time after labour, and in Case XVII.‡ a long time after labour, and after the patient had undergone great fatigue.

By Case XVI. we see that supra-vaginal elongation does not prevent conception, and we may, therefore, in many cases, ask whether it has not existed previous to the pregnancy. I would venture to regard it as sometimes congenital. In the majority of instances this hypertrophy seems due to subinvolution of the uterus, and the consecutive uterine catarrh and congestion; this may be called the congestive variety. When rectocele or cystocele has been the cause, we may call it hypertrophy by elongation.

Of the congenital, or primitive kind, the following case seems to be an example, and this opinion is strengthened by the fact that the same peculiar formation was actually found in one of the patient's sisters, while all her other sisters (five in number) were sterile.

CASE XIII.—*Menstrual derangement; leucorrhœa; incontinence; prolapsus uteri; allongement of the cervix, and chronic pelvi-peritonitis.—Amputation of the cervix; cure.*

M. S. W., aged 25, was admitted January 15th, 1861, into *La Pitié*. She began to menstruate at 15, and continued regular till she was 19, when it ceased for three months, and she was troubled with leucorrhœa and sharp pain in the right iliac fossa. At 21, she had to work very hard and lift heavy weights; this caused a great deal of pain in the lower part of the body, for which she sought advice, and was told that she had prolapsus uteri. Rest and a bandage were ordered. She continued to suffer a good deal of pain; had incontinence of urine, and difficult defœcation, a tumour protruding beyond the vulva whenever she went to the closet. She left her situation for a lighter one, still the pains continued, and she suffered greatly whenever she sat down. Sexual intercourse gave great pain, and seemed to force something upwards. She took some

* Huguier, *op. cit.*, p. 111.

† Obs. de M. Herpin (De Genève), *Société médicale d'observation, année 1854*.

‡ Huguier, *op. cit.*, pp. 210, 105, 115.

tonics, and rested. After this she had an acute inflammatory attack, for which she entered *La Pitié*, where, after the inflammation had subsided, a sponge was introduced as a pessary, but could not be borne.

After some time had elapsed, one of Gariel's pessaries was tried, but this also seemed to cause much pain, and was therefore discontinued. On examination now, the cervix was found very low in the vagina, and elongated, the fundus occupying its normal position. In the posterior cul-de-sac was a tumour, hard and painful to the touch, and scarcely, if at all, moving with the uterus. The sound measured about three inches and a-half, but did not then seem to have reached the fundus. She was ordered rest, and iodide of potassium.

Subsequently the posterior tumour seemed to increase, and became more tender, the anterior vaginal wall prolapsed in two folds. Symptoms of pelvic, or peritoneal inflammation having followed the examination with the sound, leeches, a blister, laudanum, poultices, ether, opium, and iodide of potassium were successively administered. The inflammation gradually subsided, and on examining per vaginam afterwards, two tumours were distinctly felt posteriorly, separated from one another by a groove: they were round, elastic, resistant, hot, not very tender. The uterus also was retroverted. Sexual intercourse gave great pain, and made it impossible for her to marry, which she wished to do. Finding that rest and treatment did no good as regards the *allongement*, while all else had improved, and the parts were quiet, amputation of the cervix was determined upon, and performed by M. Maisonneuve, who removed about three quarters of an inch on the 22nd of October. All went on well after the operation, and on the 21st of November the patient left the Hospital, in a greatly improved condition. She married soon after, and was comparatively well when last seen.

I think that we have here proof, that in both these patients elongation of the cervix existed prior to menstruation. The fact of the elongation in two sisters, and sterility in five, points to a congenital, I might almost say an hereditary, conformation. At any rate, the elongation was prior to pregnancy, as it was in two of M. Huguier's cases, who had never borne children. In the first of these, the patient menstruated at 19, and married at 21. When she was 24, and not having been pregnant, she felt, after lifting a heavy weight, a sudden

sensation as though something had given way in the abdomen, and violent pain in the back. As the acute symptoms abated, the cervix protruded at the vulva. M. Huguier found elongation of the uterine cavity, and well marked prolapse; the cervix, which reached the vulva in the erect posture, retreated in the recumbent. The sudden appearance of the cervix at the vulva is explicable, if we suppose that supra-vaginal elongation was already present, without giving rise to any symptom, until the strain, by causing prolapse, revealed the malformation. The second patient (reported in the note *), after having been kicked in the belly when 16 years of age, suffered some pain for a time, and soon after the cervix appeared at the vulva.

Taking it for granted, then, that cervical elongation may exist before pregnancy, I believe that it is often overlooked until the results of accouchement have brought it to light.

In M. Huguier's 32nd case,† the cervix appeared at the vulva

* Huguier, *loc. cit.*, p. 176. Obs. xxii.

Hypertrophic allongement of the sub-vaginal portion of the cervix; prolapsus; slight retroflexion; failure of pessaries; amputation of the cervix; cure.

A. L., aged 19, was admitted into *l'Hôpital Beaujon*, 20th February 1852. Menstruation began at 16. A year before admission, she had a blow on the stomach, soon after which the uterus presented at the vulvar orifice. She was taken into *La Charité*, and various pessaries were tried without benefit. On examination at the *Hôpital Beaujon*, the uterus measured four and a half inches. There was slight retroflexion. She was first treated for her general health, with tonics and local astringents, and iodide of potassium, in the hope of preventing an operation; but as no improvement resulted to the uterus, the cervix was amputated. She had a slight attack of erysipelas, which was cured by the revulsive action of croton oil to the thighs. She left the hospital cured on the 19th June, 1852. The uterus measuring two and a half inches.

† Obs. from M. Huguier's *Mémoire*. (Obs. xxxii., p. 210.)

Hypertrophic allongement of the uterus; prolapsus, and inversion of the vagina; great functional disturbance locally; incontinence of urine; amputation of the cervix; cure.

D. I., aged 21, was admitted into *l'Hôpital Beaujon*, 21st November, 1857. Began to menstruate at 17; was confined eleven months previous to admission; uterus prolapsed six weeks afterwards; has not menstruated since; procidentia four months afterwards; frequent micturition. On admission, the tumour measured externally four inches by two and a half; vagina inverted and prolapsed; uterus measured nearly five inches; bladder prolapsed. She suffered a good deal of pain and local discomfort, with incontinence of urine and frequent micturition; uterus slightly re-

six weeks after a first and easy labour. Here there must have been elongation of the cervix, existing unknown until slight prolapse, consequent on the confinement, revealed it. Nor was it until after this that a complication of disease sent her to the Hospital. Further on, I shall show that simple elongation of the cervix, without prolapse or uterine mischief, is not a cause of functional disturbance.

It appears, then, that some few cases of elongation of the supra-vaginal portion of the cervix are congenital. The majority are, however, acquired; and of these some result from imperfect involution of the uterus, after labour, either at term or prematurely, the result of some intercurrent disease.

M. Nonat furnishes us with a very good example;* for here we have intra-tubal and intra-peritoneal abscesses, with elongation of the uterus.

Women who lift heavy weights, and who work hard standing, as

troflexed; menstruation came on after the examination, on the 23rd November. The cervix was amputated on the 28th with the *écraseur*; about one and three quarter inches were removed. On December 17th, she left the Hospital quite well, and continued so fifteen months after the operation.

* *Bulletin de la Société anatomique, année 1848, p. 174.* Obs. par M. Notta.

Chronic rectitis; engorgement and prolapsus uteri; engorgement of the Fallopian tubes and purulent collection in their interior.

A. D., 45 years of age, was admitted, under the care of M. Nonat, February 19th, 1848. She began to menstruate at 18; had her first pregnancy at 23; the second at 28; and the third at 32. All births were premature. At 35, while pregnant, she had a fall; and some hours after, while coughing, the womb came down to the vulvar orifice; a bloody discharge then came on, and she aborted at the end of a month. She subsequently aborted again, and this was followed by diarrhoea, and by discharge of blood and pus per anum. On admission, this state of things continued; defæcation was painful; the uterus was procident. On the 7th March she was taken with pneumonia, and died.

On *post-mortem* examination the peritoneum was healthy; the intestine was distended with gas; its mucous membrane injected. A small cavity, containing pus, was formed by the rectum, the broad ligament, and the Fallopian tube. The entire rectum was hard, fibrous-looking, and destitute of mucous membrane, having all the appearance of chronic inflammation. The uterus was procident; the cervix so enlarged from engorgement as to be equal in size to the entire uterus. Both Fallopian tubes were hypertrophied, the right, which was adherent to the rectum, especially; small purulent cysts existed in their interior; the ovaries were healthy.

laundresses, &c., are peculiarly subject to sub-involution, brought on by uterine catarrh and congestion. M. Huguier's patients were mostly of this class.

Lastly, some cases are induced by prolapsus of the vagina. We see, in M. Huguier's case, No. XXX,* the effect of rectocele and cystocele in causing elongation. Not only do the attachments between the bladder and the cervix uteri drag upon the latter, but the vagina forms a kind of ring around it; for when released by amputation of the cervix, the uterus reascends into the pelvis.

As I have already observed, congenital elongation of the cervix, apart from prolapse, originates no morbid symptom. The leucorrhœa and irregularity of the menses are not due to this special conformation. The lumbar pains after fatigue, the obstacle to intercourse, and the sensation, as of a body being pushed up into the pelvis, when sudden movement is made, belong equally to elongation of the sub-vaginal portion of the cervix; and they are also present in true engorgement of the uterus; they are, therefore, merely general signs of uterine enlargement.

These symptoms are frequently absent until prolapse of the womb follows a strain, as in M. Huguier's case, No. XVI.† and they are often relieved by replacement of the womb, though the elongation is not, of course, affected by this remedy.

* *Loc. cit.*, p. 205. Obs. xxx.

M. R., aged 42, was admitted into the *Hôpital Beaujon*, September 29th, 1857. She had had three children; forceps had been used with the first, and the perineum ruptured. The uterus had been prolapsed four years. On admission, the uterus, which projected from the vulva, measured five and three-quarter inches; the vagina was inverted; the bladder and rectum prolapsed, and the perineum gone.

On October 18th, the cervix was amputated with the *écraseur*, it having been previously separated from the neighbouring parts, to avoid injury to the peritoneum. By the middle of November, all was well. M. Huguier then operated for the cystocele and rectocele; and on the 28th December, the patient was discharged, cured.

† *Loc. cit.*, p. 115. Obs. xvii.

A. J. F., aged 58, was admitted into *Lourcine*, June 8th, 1847. She married at 20, and had six children in fifteen years. The uterus came down after lifting a heavy weight. On examination, the cervix uteri and vagina were completely prolapsed. The vagina was thickened and indurated. The uterus measured four and three quarter inches. Reduction gave no pain, unless the uterus was pushed up to its normal position; but it could easily be borne within the vagina, and an oval pessary retained it *in situ*.

M. Huguier apparently passes over the fact of the prolapse in his cases; but his own measurements prove that it was always present to a certain degree.

In some it took place gradually; in others suddenly; and in these latter, the severe pains in the back and groins seemed to arise from violent extension, if not from partial rupture of the utero-sacral ligaments, and the strain upon their peritoneal covering, as well as that of the broad ligament. This may be so severe as to threaten peritonitis.*

A strain or fall in the early months of pregnancy may bring on abortion, and after that prolapsus. Or pregnancy may go on to term, the uterus being replaced, and the prolapse reappear after accouchement. Sometimes all the predisposing causes are present: elongation of the cervix, rupture of the fourchette, or perineum, dilatation of the vagina, and extension of the broad ligaments by pregnancy or labour. Prolapse is the natural consequence of such a state of things. When the woman begins to get about, she finds a projection at the vulva, this goes on increasing: at first it retreats if she lies down; but by-and-by congestion occurs, the uterine catarrh is augmented, and functional disturbance gives rise to considerable pain. Such a case is No. XIII. of M. Huguier.†

* Huguier, *loc. cit.*, p. 202. Obs. xxix.

A. C., aged 26, was admitted April 27, 1857. Fifteen months ago, while lifting, she felt something give way, which was followed by severe lumbar and abdominal pain; and in a few days a tumour appeared beyond the vulva, which tumour disappeared by rest in bed. Micturition was frequent. On examination, the tumour proved to be the procident uterus, which measured three and three quarter inches. A portion of the cervix was amputated, and a slight attack of inflammatory fever followed, which was relieved by leeches to the abdomen, and the rubbing in of some Neapolitan ointment. She left the hospital cured on the 20th June; and eighteen months afterwards, the uterus still remained in its normal position.

† Huguier, *loc. cit.* Obs. xiii., p. 105.

R. B., aged 40, was admitted into *Lourcine*, November 7th, 1843. Seven years previously she ruptured her perineum in a difficult labour; and a short time after, a tumour appeared between the vulva. On examination, the vagina was found completely inverted, and the uterus entirely prolapsed, measuring about four inches. By rest, the uterus returned to its place, and she left the hospital. However, but a short time after it came down again, and she returned to the hospital, March 19th, 1844, with the uterus in the same position as before. It would not now return spontaneously, though it could be easily reduced. A pessary was applied, but gave so much pain, that it was of necessity removed.

The external tumour varies in size from one to seven or eight inches. In the latter case, the lowest portion is made up chiefly of the posterior wall of the vagina. The shape depends on the congestion of the cervix, and the extent of cysto- and recto-cele. After a time the mucous membrane becomes dry, roughened, corrugated, looks like skin, in fact; and sometimes ulcerates, or becomes covered with papules. Generally, the tumour is not very moveable; in its centre, there is a solid body, the elongated supra-vaginal cervix. Passing a sound into the bladder, and the finger into the rectum, we determine the amount of prolapse of these viscera, and the position of the fundus uteri, though, sometimes, this has become so thinned as to elude the finger, trying to mark its exact limits. Abdominal palpation does not aid us much, for, on reducing the prolapse, the uterus generally becomes retroverted.

The uterine sound must not, if we can possibly do without it, be used. In the most skilled hands it has caused mischief,* and even death.† When all other means fail me, in deciding on the volume, situation, and direction of the uterus, I generally use a gum-elastic catheter, the stylet of which terminates about an inch from the end. This instrument adapts itself to any curve, without redressing the uterus, or changing its positions; which is always a hazardous proceeding when old peritoneal adhesions exist. It does not wound the mucous membrane, nor can it perforate the uterine wall. It informs us of the length of the cavity, and shows by its flexion its real shape.

From the tumour lying outside the vulva, walking is usually impeded, and the tumour itself is necessarily exposed to injury when the woman moves or sits down suddenly. Fouled by the urine and irritated by friction, it sometimes inflames or ulcerates. In young women it is a bar to coitus, and thus may be a cause of sterility.

The functions of the bladder are often interfered with; micturition becomes frequent, often difficult, and sometimes a catheter is required. The urine is apt to dribble away, and to irritate the neighbouring parts; while its retention in the pouched bladder may originate calculus or cystitis; the inflammation may involve the ureter and pyelitis terminate fatally.‡

* See Case XIII., p. 219.

† See case in the note, p. 72.

‡ Huguier, *op. cit.*, Case xiv., p. 179.

The rectum suffers less ; but still defæcation is difficult, while the straining at stool increases the uterine prolapse.

These disordered conditions are generally remedied by reduction, even when this is incomplete ; and so are the pains which the patient experiences after fatigue or long standing, the sensations of weight, of weakness, of dragging at the loins, sacrum, and kidneys, exactly as we found happened in simple falling of the womb, when these symptoms were attributed to uterine congestion similar to that of hæmorrhoidal tumours.

This functional or sympathetic disturbance is sometimes absent ; indeed, when it is experienced, other complications are usually present. Thus, in M. Huguier's case,* the *post-mortem* examination revealed cystitis and nephritis calculosa. In Case XXVI.† where the pains in the kidneys, groins, or thighs had been excessive, and the legs used to give way when the pains were not present, the symptoms being attributed to uterine disease, the *post-mortem* examination disclosed tubercle on the brain, with sub-arachnoid sero-sanguineous effusion. We must, therefore, be careful to appreciate each several complication.

The direct effect upon the uterus is very grave ; the hypertrophy of the cervix, and the position of the uterus, predispose to congestion and catarrh. The catamenia are usually more in quantity, and longer in duration, and at these periods the congestion may increase until reduction is impossible. There is generally copious mucous, muco-purulent, or sero-sanguineous discharge ; and this may be followed by pelvi-peritonitis,‡ which may become general, and end fatally. Thus, one§ of M. Huguier's patients died after she was discharged from the hospital ; another|| after an examination with the uterine sound ; and in the case that follows, fatal peritonitis supervened from over fatigue.

CASE XIV.—*Hypertrophic allongement of the uterus ; prolapsus of the uterus ; complete inversion of the uterus ; peritonitis ; death ; autopsy.*

M. F., aged 41, was admitted into *Lourcine* March 24th, 1846.

* Huguier, *loc. cit.*, obs. xxiv., p. 179.

† *Ibid*, obs. xxvi., p. 490.

‡ See Case xiii., p. 72.

§ Huguier, *op. cit.*, Case xix., p. 118.

|| See p. 72.

She began to menstruate at 18, and was pregnant at 21. On admission the uterus was protruding between the vulva, covered with the inverted vagina, it measured five inches; the os uteri was on the anterior surface of the tumour; the mucous membrane of the vagina was thick, hard, and dry. It could be easily replaced, and gave no pain, nor did the patient experience any pain ordinarily, except when fatigued. A pessary had been tried for some months, but gave so much pain that it was discontinued. At the end of March the tumour became a good deal inflamed, and there was some smart fever. Next day peritonitis set in, and she died on the 2nd of April.

On *post-mortem* examination a good deal of sero-purulent fluid was found in the abdomen, the peritoneum generally was much injected. On looking into the pelvis, great was my surprise to find the uterus in its normal position, and imagining that it had been replaced during life, I looked and found the organ still external to the vulva. There was not that large vaginal cavity filled with the intestines, which is described by authors. The uterus measured five inches and a half, and was otherwise healthy. The ovaries were inflamed and suppurated. The tubes healthy.

The mortality caused by this affection, or its complications, makes it incumbent on us to attempt a cure by operation if palliatives fail.

The tubal, vesical, and kidney affections warn us not to pass them over, and heedlessly assign all the symptoms to elongation of the cervix. Indeed, it has been too much the fashion to neglect the complications, and to fix the attention wholly on the deviation or displacement of the uterus.

CHAPTER VIII.

DIAGNOSIS.

I HAVE shown that uterine deviations, with the exception of prolapsus and procidentia, give rise to no pathological phenomena. When they appear to do so, the morbid symptoms originate in disease of the uterus and its appendages, and particularly in pelvi-peritonitis, as complications. When there is neither pelvi-peritonitis, nor abscess of the broad ligaments, there is generally uterine congestion, a condition which some call sub-acute or internal metritis; and abnormal mobility, which augments the intensity and persistence of the congestion.

The flexions have very rarely any influence in producing dysmenorrhœa, except when slight catarrh, &c., co-exists with a well-marked bend. Lastly, we have seen that the phenomena in prolapsus and procidentia are those of venous congestion; the result partly of the extra vulvar tumour, partly of the vesical and rectal displacement.

I need hardly allude to the byegone error of taking the more apparent lesion, such as ulceration of the cervix, or deviation of the uterus, to be the cause of the symptoms; we may even be in error as to the existence of the latter. I have pointed out the normal distance of the cervix from the ostium vaginæ; how, also, to avoid mistakes arising from elongation of the infra-vaginal cervix, or the shortness of the vagina; and how to recognise prolapsus uteri with or without elongation of the supra-vaginal cervix.

By the use of an enema, or laxative, we shall prevent a mistake arising from fœcal accumulation. A fibroid growth in the anterior or posterior wall of the uterus, is usually more salient than the rounded body of the uterus; and the angle formed is more acute than the hollow at the junction of the body and neck; while the

exercise of digital examination, conjoined with abdominal palpation, will generally inform us of the increased volume, as well as the position of the uterus. If other means fail, the uterine sound will clear up any doubt. I have already described the kind I employ, and while insisting on the dangers which may result from its employment, yet, in some cases, its use is absolutely required: as, for example, where a solid tumour takes the form, size, and consistence of the uterus, whether in retro- or ante-flexion, as in M. Gallard's patient.* Cystic tumours ought not to be confounded with flexion, even when small, for in them there is fluctuation; this, however, may be very obscure. Then again it may be a case of early pregnancy; or the converse may occur, and early pregnancy may be mistaken for a tumour in front of the uterus. Careful examination, however, will aid us in arriving at the truth, which a short delay will confirm.

CASE XV.—*Irregular menstruation; chancres; anteflexion; pregnancy.*

P. C., aged 19, was admitted, April 17th, 1855, into *Lourcine*. She began to menstruate at 15, but was never very regular. Has never been pregnant. In the previous September she contracted syphilis, which affected her constitutionally. On examination, an indolent, non-fluctuating, elastic tumour existed in the anterior cul-de-sac; it was continuous with the cervix, and proved, on closer investigation, to be the anteflexed fundus uteri. She was treated for the syphilis with iodide of mercury, and iodide of potassium. And in the month of July it was evident that pregnancy existed.

In this case, how readily would abortion have been induced by the use of the sound, a not unlikely procedure if the frequent micturition had been wrongly, according to our views, attributed to anteflexion,

* A woman, 28 years of age, was admitted into the *Hôpital Beaujon*, July 14th, 1854. On examination the uterus was found too near to the vaginal orifice. A tumour was felt in the posterior cul-de-sac, tender to the touch, a similar one in the anterior. At first it was thought the uterus was anteflexed, and that a tumour existed posteriorly. This opinion was confirmed by many who saw the case. It turned out, however, on examining with the sound, that the uterus was retroflexed, and that the tumour existed anteriorly; and this notwithstanding that the characters of the tumours in the two culs-de-sac pointed to the opposite opinion.

and the enlargement to uterine engorgement resulting from the flexion. Yet a digital examination gave evidence that the tumour continuous with the cervix was the body of the uterus; and that it presented the well-known peculiar elastic resistance of pregnancy; that the pain on pressure, usual in congestion, was wanting. These signs, together with the fact that frequent micturition had barely existed fifteen days, showed that the enlargement could not be either that of congestion or metritis, while a fibrous growth does not develop so rapidly.

Good practice forbids the use of the sound in such doubtful cases, at any rate, until we have seen the catamenia come on. Besides, some women will give false information with a criminal intent.

. Let us now pass on to the diagnosis of the complications.

Ulcerations of the os, granular, superficial or other, are readily detected with the speculum, should the finger be at fault. They are very often of no consequence, except as a sign of that important affection, uterine catarrh. This has too frequently been considered as a sign of deviation, although often present without the latter, together with the pain and other phenomena wrongly attributed to deviations. It is often a guide to more serious complications, such as pelvi-peritonitis. I have never met with a case of deviation which gave rise to these symptoms apart from some complication.

In almost all the cases where congestion is present, the cervix is large, bulky, purple in hue; often with fungous ulcerations, analogous to varicose ulcer. The body is also bulky and very tender, a state only met with in congestion or inflammation. There is also the sensation of weight, menorrhagia, with pain on the preceding or first day of the period, often soothed by spontaneous or artificial hæmorrhage. But I need not dilate further, for MM. Aran and Valleix have worked out the subject of uterine congestion.

Pelvi-peritonitis is easily recognised when we find, besides the uterine deviation, a tumour of greater or less size, hot, painful to the touch, separated from the cervix by a depression, sometimes presenting arterial pulsation, the containing cul-de-sac being painful on pressure. The well marked general symptoms also help us. But the diagnosis is more difficult in old pelvi-peritonitis, when the finger discovers nothing but some hard isolated nodules, to which M. Gosselin has often called attention. And the difficulty is greatly increased when the only marks left are peritoneal adhesions; some physicians declare that they have never met with such cases, but the facts I have re-

ported, which agree with those published by M. Ameline,* M^dme. Boivin,† and M. de Scanzoni,‡ together with the autopsies made by Richet,§ establish their existence. These adhesions are seldom so firm and tense as that the fingers can feel them like bands stretching across the vaginal cul-de-sac. Yet, on moving the uterus, we find resistance in certain directions, and an attempt to overcome this causes sharp pain, and sometimes a dragging sensation like that experienced on excessive fatigue. We have still better evidence in the general symptoms, the history, and the frequent relapses indicated by the recurrence of pain, a chief characteristic of pelvi-peritonitis. A chronic form of pelvi-peritonitis, without tumour or induration, sometimes comes before us, the distress arising from which we might be tempted to refer to the deviation. Here the history and attendant circumstances will be our guides, and if we wait until menstruation or a relapse occurs, the congestion of the uterus and its appendages will reveal some induration where, though pressure was painful, we could not before feel anything. Moreover, in these cases we find the vagina globular, the walls being drawn apart, and vault-like, and this condition, though not pathognomonic, exists sufficiently often in cases of chronic pelvi-peritonitis, terminating by resolution, to merit attention. But the patient's history and the progress of the disease are our chief guides. The symptomatology has been described at length in the first part of this volume.

* Ameline, *Thèse*. Paris, 1827, No. 55, obs. xiv., p. 43.

† Boivin et Dugès, t. i., p. 214.

‡ De Scanzoni, *traduction française*, 1858, p. 130.

§ Richet, *Anatomie chirurgicale*. Paris, 1857, p. 720.

CHAPTER IX.

TREATMENT.

It has been my aim, in the preceding pages, to prove that deviations of the uterus, when simple, with the exception of prolapsus and procidentia, do not cause any functional disturbance; but when complicated with old pelvi-peritonitis, or uterine catarrh, or congestion, the faulty position, and the abnormal mobility of the uterus are a source of pain and demand treatment.

The first general indication is founded on this fact, observed in all the varieties of complicated deviations, viz., the remarkable amelioration of pain by rest, and its augmentation by standing, walking, or hard work. M. Malgaigne was thus induced to regard the pain as a mechanical phenomenon belonging to uterine deviations. Lisfranc treated engorgement and deviations of the uterus by confining the patient to her bed. Unfortunately, most affections of the uterus require a very long course of treatment, and a long confinement to bed is prejudicial to the general health, and so is often a bar to the expected recovery. But while we abandon this practice, we must not lose sight of the great point that rest gives relief in cases where the deviation is accompanied by a congestive or sub-inflammatory condition of the uterus or its appendages. Endeavours have been made to fulfil this indication by means of various instruments, either belts or pessaries. The original intention of the inventors was to remedy the faulty direction of the uterus; but M. Barnier has shown that they all* act by steadying the womb without replacing

* The so-called intra-uterine pessaries are different in their action. MM. Velpeau and Amussat were the first both to try and to give them up, then Simpson of Edinburgh, and Valleix in Paris, used them for some years, but they were finally abandoned in France after the discussion in the Academy in 1854. I have no wish to reintroduce them; the dread I

it in its normal position. We have already seen, in many cases of deviation, which have become painful through uterine congestion, that the suffering diminishes as the mobility and "ballotement" of the uterus are diminished; and once the organ has returned to its normal size, it becomes free from functional disturbance, whether it has regained its normal position, or remains in a faulty direction.

But just as too long confinement to bed is hurtful, so pessaries or other instruments may prove mischievous if they render the uterus too immobile. The uterus naturally enjoys a certain amount of mobility; but many of the pessaries used against deviation cause either a flexion or another version,* though not more inconvenient than the primary one. These various palliative remedies give relief, and help us in effecting the cure of the uterine or peri-uterine disease, co-existent with the deviation; but they can only be used at certain times. The acute stage must have passed over. They

have of the uterine sound is quite sufficient to insure my rejection of any instrument of the kind. I could never advise a plan of treatment that has once proved fatal for an affection which, though troublesome and painful, has no tendency to death. It is worth while, in a scientific point of view, to examine the mode of action of these instruments, and how they sometimes brought about relief and sometimes fearful mischances. No one can deny that the use, both of the intra-uterine redresser and of the sound, has caused death, but sufficient notice has not been taken of the grave complications that accompany the deviations, and which have been revealed by the autopsies. Bearing these in mind, we may avoid a similar misfortune.

After reading carefully the cases of Valleix and M. Piachaud, I do not feel at all certain that the version, still less the flexion, has often been redressed, although relief has been marked. But we find that, while the intra-uterine pessaries fix and make some change in the position of the uterus, certain phenomena occurred which have hitherto escaped attention, but which seem to me to exercise considerable influence in the cures effected by these instruments. First, there was the metrorrhagy; this, which Valleix thought an obstacle to the treatment, I consider as acting most beneficially by diminishing the volume of the uterus, and it happened in every patient who received benefit, though Valleix imputed the relief to the redressing of the womb. Secondly; sub-acute inflammation of the uterus or its appendages followed the application of the redresser. Valleix considered this as requisite for the cure, by modifying the condition of the uterus, and doubtless, it often had a good result, but sometimes pelvi-peritonitis, and even fatal peritonitis occurred. This inflammation necessitated rest, and to this, and to the immobility of the uterus, and the metrorrhagy, I believe the benefits which have been assigned to the redressing really belong.

* See case in the note, p. 187, and Case VIII., p. 205.

must be easy and painless when applied, for we have seen* their untimely application, in a case of chronic pelvi-peritonitis, bring on a fatal relapse. A pessary ought, therefore, never to be used until all sign of inflammation, whether of the uterus, or of the appendages, or of the pelvic serous membrane has quite passed off, and it is not always easy to be certain of this.†

We shall not always be able to choose beforehand out of all the belts and pessaries which have been proposed the exact one which will succeed the best; but as they may be of service, and it is troublesome to try a great number, I will point out the principal instruments, with their advantages and disadvantages, and the particular cases for which they are specially suited.

The abdominal belt is, without doubt, the simplest, least irksome, and, therefore, one of the best of these instruments, and without professing the same admiration for it that M. Malgaigne does, I believe that it often gives great relief, and causes no mischief. It does not act, as some have thought, by holding up the intestines, and diminishing the pressure on the uterus; but, as MM. Castelnau and Barnier have shown, it acts by diminishing the abdominal capacity, and thereby the mobility of the contained organs. M. Barnier‡ has proved clearly that the abdominal belt, instead of diminishing the weight, supported by the uterus, thrusts that organ downwards, and lessens its mobility. In whatever way it acts, and whether it is furnished with metallic plates, or is a simple cotton belt like the one figured at p. 163, it gives great comfort to many. The relief afforded is the same; whether the uterus be ante- or retro-verted, ante- or retro-flexed; unfortunately, it is of no use when the uterus falls low, or is more or less prolapsed, then we must have recourse to the different pessaries.

In the majority of cases, the pessaries fulfil the same indications as the belt; and, moreover, fix and keep up the uterus; but these advantages are counterbalanced by certain inconveniences. Not to speak of the excessive cleanliness required, and the knowledge how to introduce and place them in position (for a pessary is not a good one unless the patient can withdraw it at night), they are dangerous. Perforations of the rectum, or of the bladder, and the incrusta-

* See case in the note, p. 96.

† See case XIX. in the preceding Part, p. 97.

‡ Barnier, *Thèse inaugurale*. Paris, 1855.

tions by which the vagina has become excoriated, necessitating a surgical operation to extract the pessary, are due to its abuse, and not to any fair use. But admitting this, the pessary is not always harmless. We have seen* the application of a caoutchouc pessary to a woman, who suffered from prolapse, with old pelvi-peritonitis, cause a recurrence of the latter, and death. I lay the greater stress upon this case, because it often happens that we neglect to trace out the co-existence of some old pelvi-peritonitis; and it is precisely in such cases that slight mechanical experiments may light up fresh peritonitis, though it is generally not very serious. But this case proves the necessity of using great caution, and of not introducing a pessary until all acute symptoms are quite gone. As a pessary is simply a palliative, common sense tells us that it must neither be introduced, nor its use continued, if pain results. Pessaries are liable to increase leucorrhœa, to enlarge the vagina, and so lessen the support for the uterus. These objections are of greater or less consequence, according to the kind of pessary used; but as regards many of them, their size is often gradually increased, and the dilatation of the vulvar orifice goes on until they drop out on the least movement.

The ring pessaries, whether round or oval, act by distending the vagina; and by thus shortening it, they bring the uterus lower. They are often useful, especially in cases of hypertrophic elongation of the supra-vaginal cervix, with a tendency to prolapse.†

The cylinder pessaries, and the winged one of M. Jules Cloquet, dilate the vagina less, and oppose the falling of the womb; but they do not correct the fault of position, and may even exaggerate it. M. Barnier‡ has shown, on the dead body, that they make the fundus uteri approach the sacro-vertebral angle, and this is confirmed by the cases§ reported above, where retroversion was caused by one of these instruments.

M. Gariel's air pessary of vulcanized india-rubber is softer, less painful, and much easier for self-application than the above; but it is expensive, and liable to slip out of the vagina.

The sponge requires excessive cleanliness; it is cheap, and steadies

* See case in the note p. 96.

† See case in note, p. 682.

‡ *Thèse déjà citée*. Paris, 1855.

§ See case in note, p. 187.

the uterus well when placed in one of the vaginal culs-de-sac. It can also be medicated.

The pessaries of M. Hervez de Chégoïn, and especially the spade-shaped one used in retroversion, keep the uterus steady and high up. For some days previous to using it, M. Hervez de Chégoïn endeavours, with a curved pessary, to restore the fundus uteri to its normal position. I am not aware that any accident has happened to a patient in his able hands; but the proceeding is a very dangerous one, especially as retroversion is so frequently the result of old pelvi-peritonitis.

We must not suppose that the instrument remains exactly where it was placed; generally, after a time, it turns to one side, so that the upper end occupies the lateral and posterior cul-de-sac. In this position it keeps the uterus high up and fixed, rather than opposes its backward tendency. The results are however good, and marked relief is afforded in cases of retroversion and prolapsus, when the acute and sub-acute conditions have quite subsided.

Unfortunately, all these pessaries have one common defect. They can only be used when the vulvar orifice is not much enlarged, or the perineal laceration is but slight. Some of them, as the oval and air pessaries, dilate the vagina, and gradually the vulvar orifice also. They are then apt to fall out of the vagina, if the patient makes a sudden movement, or is obliged to strain herself. To remedy this inconvenience many forms of stem pessaries, some being cupped at their uterine extremity, have been invented to be kept in place by a bandage; but this is apt to rub and irritate the vulva, and then the patients are obliged to leave them off. The vulvar perineal pad worn in similar cases gives rise to the same inconvenience, though in a less degree, besides it is only a very insufficient palliative remedy, merely preventing the cervix from protruding beyond the vulvar orifice.

To escape these difficulties, sundry pessaries have been invented of more complex form, which, by separating the vaginal walls at their upper extremity, shall thus indirectly support the uterus. Unfortunately, the construction of these pessaries is generally so complicated that they are liable to get out of order, and require great care in their adjustment. Their use is, therefore, of necessity confined to a very limited number of patients. As, however, they may prove serviceable in cases of incomplete prolapse, I will describe them.

The elytromochlion of Dr. Kilian resembles the American pessaries

(Hodge's?), and consists of a very soft spring, bent into the form of U, the extremities being blunt plates of some thickness, covered with caoutchouc. To introduce it, press together the two arms, these, when released, are separated by the action of the spring, and, stretching the vaginal walls, indirectly support the uterus. The spring of the instrument keeps up a constant pressure, and this is not always well borne, but, causing irritation of the vaginal mucous membrane, and increased secretion, sometimes becomes so painful that the instrument has to be laid aside.

From the difficulty in keeping up the uterus, and its aptness to prolapse when the perineum has been torn to any extent, it is plain that we cannot be too careful to guard against its laceration during labour, and to restore it when the rupture has unavoidably occurred.

On this account I think we ought to try and get reunion of the ruptured parts, either by the application of "serres fines" immediately after the accident, or by means of the interrupted suture put in before the parts have cicatrised asunder, and while union can still be obtained without making a fresh raw surface. Unfortunately, it is often very difficult to hit upon the right moment for this operation; during the first three or four days after the confinement, the lips of the lacerated perineum are in a granulating state, and there is often danger in operating on a woman so recently delivered; sharp pain is caused, the moving of the patient, and the position expose her to taking cold, and, above all, the mental agitation may arrest the flow of the lochia. On the other hand, if we wait until the tenth or twelfth day, there will hardly be a sufficient granulating surface left for reunion to take place.

I prefer, then, to operate from the fifth to the eighth day after the confinement, if the state of the patient allows it. But, unfortunately, when the operation succeeds, we have no absolute security against prolapsus, for frequently when the perineum is whole the prolapse, though partial, will gradually distend the vagina, so that it becomes impossible to apply, or at least keep in, any of the pessaries I have mentioned. This is especially the case when prolapsus is complicated with cystocele. To meet this difficulty, Zwanck invented a peculiar "hysterophore," by which he tried to avoid the mischief caused by the spring in Dr. Kilian's pessary. To take the place of its action, Zwanck employs two plates or oval wings of lacquered tin plate, hinged together, and carrying at right angles to their external and inferior aspect two metallic stems. On drawing these together the

wings diverge, and are kept in a horizontal position by a small screwed nut, which fastens the stems together. The objections to this hysterophore are that it is made of metal, and the screw is liable to get out of order. Eulenburg has improved it, by making the plates and stems of boxwood, and fastening the latter together by a strong ring of india-rubber. This, which is fixed at the base of the instrument, keeps the plates asunder by its elasticity.

These instruments certainly do good service, and they possess the advantage of being readily withdrawn and replaced. But unfortunately there are some cases where the size of the uterus, and especially its elongation, has advanced so far that all these pessaries fail. M. Aran has here tried to prevent complete procidentia by passing a ring through the nymphæ, but the operation does not always succeed in arresting the prolapse.

In these difficult cases recourse has been had to more complicated instruments. Roser's hysterophore, modified by Scanzoni,* consists of a piece of tinned plate covered with leather, and shaped like a kidney for the hypogastrium, it measures 14 centimetres ($5\frac{1}{2}$ inches) in length, and $8\frac{1}{2}$ centimetres ($3\frac{2}{3}$ inches) in breadth. Into this is screwed a wire which is curved for introduction into the vagina at 5 centimetres (2 inches) below, and fitted to the pad is a hinge which allows right and left motion. Thence the wire descends for $5\frac{1}{2}$ centimetres, and then bends backwards, upwards, and forwards, describing such an arc of a circle that there shall be $5\frac{1}{2}$ centimetres ($2\frac{2}{3}$ inches) at the point of greatest distance between the ascending and descending branches. The curved wire is made of strong steel spring .005 millimetres thick ($\frac{1}{3}$ inch), covered with vulcanised india-rubber tubing, it ends in a button of ebony 4 centimetres long, 3 centimetres broad, and $1\frac{1}{2}$ centimetres thick, which is so fixed by a screw, that it can be raised or lowered at pleasure. The instrument is very useful in procidentia or prolapsus complicated with cystocele, but it will not remedy a rectocele. I should also add that the genital organs must not be too sensitive, for, like all the stem pessaries, it then brings on so much irritation of the vagina and vulva, that the patient is soon obliged to leave off wearing it.

The pessary of M. Grandcollot, lately reported on at the

* De Scanzoni, *Traité des maladies des organes sexuels de la femme*. Paris, 1858.

Imperial Academy of Medicine,* only differs from that of M. Roser in supporting the uterus on an intra-vaginal cupped stem, instead of making the vagina its "*point d'appui*." The pessary consists of a belt having two pads, carrying a metal rack, in which works the swan-necked rod which supports the pessary, and is curved to pass over the pubes. This rod can be fixed or turned in any direction by means of a double hinge. To the rod is fitted an intra-vaginal stem, terminating in a cup. The stem is straight, and consists of two tubes with a telescope joint, so that it can be lengthened or shortened at will; within it is placed a spring which keeps its tension, whatever may be the length of the stem, and allows about a centimetre ($\frac{2}{5}$ inch) of vertical motion. By an eccentric mechanism it can be turned more or less on its axis, and even make a complete revolution. It can, therefore, be easily introduced. The stem is also jointed with the swan-necked rod in such a manner, that it can be bent upon itself or move in a circle. M. Robert's report to the Academy gives evidence of the serviceableness of this very ingenious pessary, but it is very complicated and expensive. Moreover, like the hysterophore of M. Roser, it irritates the vaginal and vulvar mucous membrane, and so cannot be worn constantly; occasionally, too, the mucous membrane gets pinched in the sliding parts. Lastly, as we see in the case below, reported by M. Caulet,† the

* *Rapport à l'Académie impériale de médecine*, par M. A. Robert, 11 janvier, 1862 (*Bulletin de l'Académie*, t. xxvii., p. 391).

† *Hypertrophic allongement of the infra-vaginal portion of the cervix, cystocele, and subsequent prolapse; employment of the articulated pessary of M. Grandcollot*.

A. F., aged 33, was admitted into *Hôtel Dieu*, under the care of M. Robert, September the 17th, 1861. She was of good constitution; her mother had never had any uterine disorder. She began to menstruate at 18 without any discomfort; the periods being regular, and moderate in quantity up to the age of 30, when she married. She soon became pregnant, went to full time, and was delivered naturally. After her labour she continued ailing for some time, and left the Hospital without being cured. She complained of pain in the loins, hypogastrium, and thighs; the pains being worse on standing. As this continued for six months or more, she was admitted under the care of M. Robert. By rest, and the employment of a pessary, the pains greatly diminished, and the patient left the Hospital nearly well. She was able to perform her household duties, and continued pretty well for fifteen years, up to about the year 1854.

About this time, after a violent effort, she felt a sharp pain in the womb, something gave way, and a tumour presented itself beyond the vulva. At the same time the patient experienced great pain in the loins and hypo-

instrument is not suited to cases complicated with cystocele, as it sometimes induces incontinence of urine. Besides, the complicated arrangement is apt to get broken or put out of order, and so is a continual source of expense and trouble. While, like all the instruments which embrace the cervix, it frequently is found on examination to be resting in the posterior cul-de-sac of the vagina, instead of keeping up the cervix. Being dissatisfied with these pessaries, I modified the hysterophore of M. Roser, for a patient whose case will be reported further on, and this instrument, as it seems to me useful, simple, and cheap, I will now describe.

gastrium, accompanied by vomiting, rigors, and fever, for which she was confined to her bed for two months. By this time the tumour disappeared, but came down again on standing. She complained then of a feeling of weight and bearing down in the vagina and rectum, with frequent desire to micturate, and difficulty in doing so, with occasional incontinence of urine, cramps in the stomach, &c. These symptoms went on increasing, and compelled her to re-enter the Hospital. Pessaries were applied as before, but this time they came out as soon as she got upright, and at last one was found to fit. She again left the Hospital, because she feared the cholera which broke out in the Hospital. The pessary in a little time gave her great inconvenience, and she sought advice of M. Simonot, who applied what is called a "quenouille." This answered very well for a time, but it was soon as bad as ever. All the symptoms returned. Menstruation, however, did not return, but there was very free leucorrhœa. From contact with the urine, and friction in walking, the tumour soon became excoriated and inflamed. On the 17th September she was admitted into *Hôtel Dieu* with fever, &c.; tonics and evacuates were given, and in about six weeks, under the influence of rest, she greatly improved.

On examination, the uterus was much prolapsed; the vaginal culs-de-sac were lessened in depth; the surface of the tumour indurated; the bladder was also prolapsed, the rectum not at all. Examining with the sound, the uterus measured nearly six inches in length. A great variety of pessaries were tried.

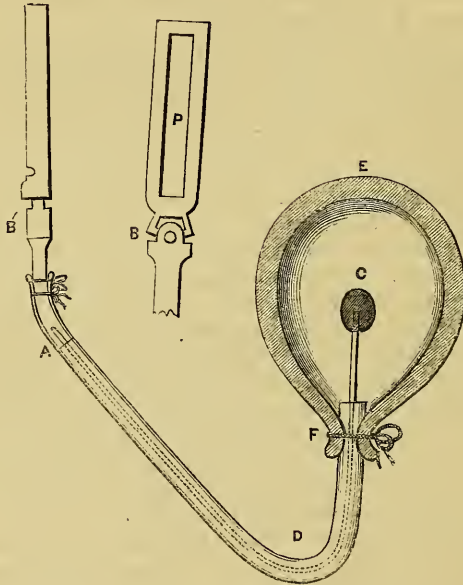
On November 6th, a pivot pessary was applied with an abdominal belt. It was easy while recumbent, but caused pain in the upright position, especially on bending forwards, and on sitting down. At last it gave so much pain, she was obliged to have it removed.

On the 9th, M. Robert applied the articulated pessary of M. Grandcollot, and the result was most satisfactory.

On the 13th of April, 1862, the patient reported that she had re-applied the instrument three times since she left the Hospital, because it had got out of order. It had kept the uterus in good position, and enabled the patient to do some work: she had not suffered from any incontinence or difficult micturition, but generally she suffered some pain from pressure on sitting down. In other respects she was greatly improved.

The pessary, which is figured here, consists of a metal plate (P), having a slot in the middle, by which it is fitted at any required height by a set-screw to the plate of an abdominal belt. This slotted plate, which on my patient is almost vertical, can be set at any angle required by the corpulency or size of the abdomen of the wearer. A hinge at B, which allows of a certain amount of lateral motion articulates it with the swan-necked rod A D C. This last

FIG. 21.



(A D C) is a strong rod $\cdot 005$ millimetres thick ($\frac{1}{4}$ inch), bent in the fire to the shape figured in the woodcut, to permit of the patient stooping forwards or sitting on a hard seat. The intra-vaginal portion of this stem from D to C is vertical and only $\cdot 05$ millimetres (2 inches) long; it ends in a metal ball at C. A C is covered with vulcanised india-rubber tubing, and carries at the intra-vaginal extremity a thick india-rubber ball, measuring transversely from $\cdot 03$ millimetres to $\cdot 04$ millimetres, and being from $\cdot 05$ millimetres to $\cdot 06$ millimetres long. This egg-shaped ball is filled with air, which is kept in by a string which fastens the ball to the rod at point F, exactly half way up the ascending branch.

The pessary has its defects, and I shall say nothing further in

its favour, as I have only tried it on one patient. But it is cheap, and does not cause more discomfort, nor vulval irritation to the patient, than the air pessary of M. Gariel. There is no question but that these instruments are always inconvenient, require much attention, and, in short, are but palliative remedies of a very defective kind. For this reason attempts have been made to give relief by operations, some of which have been of a very serious character.

I do not intend to describe the various operations which have been performed, nor to give any opinion about them; I shall look only at the results. First, then, we must admit that we do not possess any certain remedy against simple descent of the uterus. The various methods of contracting the vagina, whether by caustics, by the scalpel, or the forceps of Desgranges, have almost always resulted in failure.

Attempts have been made to partially occlude the vulva. Passing a ring through the labia majora is the mildest proceeding, but it is almost always useless.

Episioraphy, or the uniting the labia majora along their median line, by means of the scalpel and suture, seldom succeeds; usually the flaps fall apart, and when this does not happen the labia become so stretched that the tumour escapes, the operation therefore is very seldom really successful.

Episioraphy combined with perineoraphy, practised by MM. Baker Brown, and Stoltz, has succeeded as far as regards the operation; that is to say, no death has occurred, and union of the raw surfaces has almost always taken place. But, unfortunately, the relief has not been permanent. In some few cases straining has brought back the prolapsus. I think, therefore, that in simple descent of the uterus, which occurs chiefly in very aged women, we should content ourselves with palliative remedies.

The case is different when descent of the womb is complicated with hypertrophic elongation of the infra-vaginal portion of the cervix, met with usually in young women: here the obstacle to sexual intercourse interferes with social happiness. When, too, we consider that so long as we leave the hypertrophy of the infra-vaginal cervix unremedied, the slightest cause will increase the descent, inducing copious leucorrhœa, with special tendency to local and general peritonitis, we shall be greatly disposed to have recourse to resection of the cervix; an operation usually free from danger, provided we delay it until any pelvi-peritonitis complicating the descent is completely

cured. Up to the present time no accident has followed resection, even when practised with the knife in the manner prescribed by M. Huguier, although it obliges us to drag down the cervix outside the vulva. We can avoid this difficulty, always dangerous, and especially hazardous when peritonitis has previously occurred, by using the *écraseur linéaire*, or, better still, the *serre-nœud écraseur* of M. Maisonneuve. On this account I prefer this mode of operating, as it is very simple, and has the great advantage of only setting up slight inflammatory reaction, as in the case already quoted.*

Palliative remedies are of least use where descent of the womb, and hypertrophy of the infra-vaginal portion of the cervix are complicated with cystocele: unfortunately a case of frequent occurrence. Here we must first of all try every application, and then rest contented so long as the descent of the womb does not entail too great suffering. Operations in these cases are too formidable and serious to be performed until we have exhausted every other kind of remedy. I would never even have advised an attempt of the kind had I not found, on perusing the various cases, that elongation of the supra (*sub-?*) vaginal portion of the neck, with partial descent of the womb, was a special predisposing cause to both local and general peritonitis, which might end in death.

These important considerations seem to me to furnish a complete justification of the very ingenious operation that M. Huguier proposed and carried out. In the hands of my able colleague, a bad result has but seldom occurred, and in the few cases where death has followed it has been due, apparently, to extraneous causes. We must not, however, conceal from ourselves the difficulties of the operation, and the danger of opening the recto-uterine peritoneal cul-de-sac. These difficulties have the greater weight when we find that, although a perfect cure has frequently rewarded the operator, occasionally the success has been but temporary, as in the case below.†

* See Case XIII., p. 218.

† Obs. par M. Huguier, p. 195.

Hypertrophic allongement of the cervix; retroflexion; complete inversion of the vagina; ulceration; incontinence of urine and metrorrhagia; laceration of the perineum; various remedies tried without success; amputation of the sub-vaginal portion of the cervix; cure in progress.

S. B., aged 37, was admitted April the 28th, 1856. Up to the age of 17 she enjoyed good health, when menstruation began irregularly, and with pain; after three months it ceased for three years, and was replaced by profuse leucorrhœa. At the end of that time the uterus became prolapsed,

I have no intention of going through the steps of the operation. I suppose no surgeon would undertake such without reading and thinking over the directions and precautions, as well as the cases which M. Huguier has most minutely detailed. In reading over these cases, one point suggests itself: we find that the operation, full of difficulty and danger, only removes about $\cdot 04$ millimetres ($1\frac{1}{10}$ inch) to $\cdot 05$ millimetres (2 inches) at most of the cervix, while the

and appeared at the vulvar orifice. After this menstruation returned irregularly, and there was an occasional hæmorrhage. The patient stated that she had never been pregnant, and only once had had sexual intercourse, but an examination of the abdomen and genital organs cast a doubt over this statement, and there were reasons why she should not convict herself of this offence. On walking for some time the uterus descended more and more. The patient experienced a good deal of pain in the loins, and bearing down, with constant desire to pass water, and habitual constipation. M. Barnier tried to introduce a pessary, but it would not remain *in situ*. All work was impossible, and in October 1854 she came under the care of M. Huguier. For seven months she was kept constantly in bed with the pelvis raised, the uterus being kept *in situ* by attempts to contract the vagina and vulva, by the use of the actual cautery. Then an ulcer appeared on the cervix, which was cured by the use of ointment. But as the prolapsus did not improve, she left the Hospital in about the same condition, in August, 1855.

She returned in April 1856; while resting she experienced no pain or discomfort, but on standing for a few minutes a sense of weight and bearing down came on, and a lump appeared at the vulva. Walking then became impossible, except with great pain. Any attempt at defæcation or micturition brought the uterus down, and when it came out the patient complained a good deal of dragging in the loins, a sense of compression on the anus, frequent desire to pass water, and what most annoyed her, a good deal of violent pain in the tumour itself, like a knife cutting her. When she lay down the tumour disappeared, and all pain ceased. On examining them, the finger at once detected the cervix uteri with the vaginal orifice, it was large and dry.

When the tumour was down it was evidently the uterus, covered with the inverted vagina. Over the uterus the mucous membrane was freely moveable, but it was very dry, and resembled skin. In front and back the vagina was completely inverted, but laterally the culs-de-sac were about normal. Upon the cervix there was a large painful ulcer; the bladder was prolapsed on the anterior surface of the uterus. The os uteri was very small, requiring a small sound to measure it; its length was about four inches and a half, and the fundus was retroflexed, but could easily be replaced. It was determined to amputate the cervix uteri.

On the 24th of June a semi-circular incision was made on the posterior aspect of the tumour, at about an inch from the summit of the cervix; the

length of the uterus is sometimes from $\cdot 015$ millimetres (6 inches) to $\cdot 020$ millimetres (8 inches), and $\cdot 025$ millimetres (10 inches). It follows that if, in spite of this length, the uterus rises into position, or even higher, it cannot be solely due to amputation of a portion of the cervix. The ascent appears to be consequent on inflammation of the diminished cervix, together with that of the upper portion of the vagina and the neighbouring parts, morbid adhesions take place and general inodular contraction of the parts, circumstances which play a very important part in maintaining the uterus in its new position.

Reflecting thus, I was induced to try whether, in like cases, I could not obtain the same result by removing simply the over-grown portion of the cervix at the point where the vagina is inserted. The operation does not remove more than $\cdot 02$ millimetres ($\frac{2}{100}$ inch) instead of $\cdot 04$ millimetres ($\frac{1}{25}$ inch); but this slight difference seems to be quite outweighed by the facility and safety of the operation; since we run no risk of involving the peritoneal culs-de-sac, and moreover, by employing the *serre-nœud écraseur*, we avoid the dangers attendant on dragging the uterus down. We have

recto-uterine peritoneal cul-de-sac was then dissected off, and the incision carried through the cervix to its cavity. A sound having been introduced into the bladder, and pushed down on the anterior surface of the tumour, the dissection was then carried on in front in the same way as it had been behind, and the portion of the cervix was removed. Six ligatures were employed.

After the operation the tumour presented a conical aspect. Some straps of adhesive plaster were applied to it, together with some compresses; the patient was kept in bed with the pelvis raised, and some Neapolitan ointment rubbed into the abdomen as a precautionary step. A good deal of bleeding followed, which was controlled with cold; the urine was drawn off for several days. Some rather free suppuration followed, which however greatly diminished when the ligatures came away.

On the 20th of July she had recovered sufficiently to get up; but on the 26th she had a rather smart febrile attack, which proved to be the return of menstruation. In a few days she recovered and went out. At the end of August she again complained of a good deal of pain in the loins, with headache and quick pulse. She had an attack of retention of urine, requiring the catheter. This soon passed off, but menstruation did not then return. At the end of September, 1856, she left the Hospital. There was then slight vagino-rectocele; the cervix was high up and completely cicatrised. The patient was seen again a year later; there had been a slight return of the prolapse, but it did not occasion any inconvenience, and there was no retroflexion.

tried this method in two cases, one of which is reported above, and the second, though first in date, I shall now detail.

CASE XVI.—*First pregnancy at 32; prolapsus uteri nine days after, treated with a pessary; second pregnancy followed by increased displacement, treated by another pessary; repetition of the mischief after a third pregnancy, and use of Gariel's pessary; cystocele and hypertrophic allongement of the cervix; amputation; cure; reproduction of the cystocele; employment of Roser's hysterophore.*

J. P., aged 43, was admitted into *La Pitié* on the 15th of July, 1861. Her family history appeared to be satisfactory, and during her early life she enjoyed good health. Menstruation came on at about 13½, had always been regular, lasting about two or three days, and not being followed by any leucorrhœa. In 1845 she came to Paris, and in 1849 she had an attack of cholera, after which she did not menstruate for nine months. At 32, she married, and soon became pregnant, went her full time, and was delivered naturally. She kept her bed nine days, and when she got up she washed her neck in cold water. This, however, did not arrest the lochia. A week after this she first noticed a swelling at the labia; for which she was ordered to rest in bed; this she did for ten days, then Dr. Martin applied a pessary. At 33 she again became pregnant, she suffered more this time, and the uterus became more prolapsed. She was delivered at *Hôtel Dieu*, after which the uterus again came down, and a pessary was applied. At 36 she was again pregnant, when precisely the same symptoms returned; but now the pessary would not stay in. In 1857 she applied one of Gariel's pessaries, which she wore for three years; but at last it also began to come out on any exertion, and she gave it up. She now wore an abdominal belt, and unless she fatigued herself, the prolapse did not occasion any particular inconvenience. Any great exertion, however, brought it down a good deal, and caused her much discomfort; it seemed also to take her strength away. She was often obliged to press up the tumour before she could get the bowels to act. Micturition was ordinarily easy unless the uterus was a good deal down. Menstruation was regular, not painful but scanty. In all other respects she enjoyed very good health.

On examination, July 17th, the vulva was somewhat patulous, and the anterior wall of the vagina was projecting through it. The cervix uteri was depressed and elongated, more particularly on its

posterior part. The body of the uterus was enlarged, placed posteriorly towards the sacrum, with the fundus so increased in size as to seem like a retroflexed organ. No tumefaction was discoverable in either of the lateral culs-de-sac. The cervix formed a sort of truncated cone; the os was open; but there was no ulceration. The sound measured 125 millimetres, and its passage gave no pain.

After being on her feet a little, the anterior wall of the vagina came down more prominently, and the cervix approached the vulvar orifice, especially on coughing, &c. There was now slight retroflexion and retroversion, and by combining abdominal palpation we could, by firm pressure above, force down to within easy reach a round soft tumour, not very tender, and feeling something like a knuckle of empty intestine. The posterior cul-de-sac was much deeper than the anterior, it was also free and supple in this position; thus proving that the retroversion observed when the patient was recumbent, was now changed into anteversion. These several measurements may thus be seen:—

| | | |
|---|-------|-----------------|
| From the vaginal orifice to the cervix | . . . | 40 millimetres. |
| " " anterior cul-de-sac | 60 | " |
| " " posterior ditto | . 110 | " |

M. Maisonneuve, on the 24th of July, performed amputation of the cervix under chloroform, in the way recommended by him. About 15 millimetres was excised.

For the next few days, all went on perfectly well, but on the 29th she did not feel quite so comfortable, and on examination the vulvar orifice felt swollen; but there was no pain or tenderness, and except the soft tumefaction felt in the posterior cul-de-cac none other was felt. The cervix and fundus uteri were somewhat enlarged, tense, and hot.

On the 1st of August the patient got up for a few hours, and felt no inconvenience therefrom, on the contrary, in place of the feeling of fullness and weight, there was rather a sense of emptiness. The cervix was somewhat large and regularly conical. The measurements in the recumbent posture were:

| | | |
|---|-------|-----------------|
| From the vaginal orifice to the cervix | . . . | 50 millimetres. |
| " " anterior cul-de-sac | 80 | " |
| " " posterior ditto | . 110 | " |

She was ordered to keep in bed, and on the 9th of August it was reported that no swelling came down when she went to the water-

closet, nor was there any particular change in the condition of things; on examination the measurements were:—

| | |
|-------------------------------|-----------------|
| To the cervix | 55 millimetres. |
| „ anterior cul-de-sac | 72 „ |
| „ posterior ditto | 103 „ |

An attempt was made to sound the uterus, but as it gave pain it was abandoned. She left the Hospital next day.

On the 31st she was again examined; nothing had appeared at the vulva, though the patient had been a good deal on her feet. The anterior vaginal wall was certainly more dependent. The culs-de-sac were about the same, except that the fundus was more distinctly felt posteriorly. The measurements now taken were as follows:—

| | |
|-------------------------------|-----------------|
| To the cervix | 35 millimetres. |
| „ anterior cul-de-sac | 50 „ |
| „ posterior ditto | 92 „ |

On the 15th of September, the anterior vaginal wall was more markedly prolapsed, and she felt weaker and more depressed. On examination, however, the measurements were about the same. The parts occupying the same relative positions. Fearing lest this prolapse of the anterior vaginal wall might go on increasing and in time pull down the uterus with it, I ordered her to use one of the pessaries described at page 240. This seemed to have the desired effect, and the patient expressed herself as feeling decidedly the better for it; but it gave rise to some little leucorrhœal discharge. She has since continued the use of this pessary, and has appeared to be perfectly satisfied.

I acknowledge that in this case relief only, and not a cure was obtained; and I am aware that this method of operating is open to the objection, that the portion of the cervix removed is insufficient, and that a conical cervix is left instead of the bevelled one of M. Huguier. As I do not wish to go beyond the medical point of view, I shall leave others to determine whether a more satisfactory result cannot be obtained; perhaps the line of amputation might be drawn nearer to the insertion of the vagina, especially at the anterior cul-de-sac. I am only bound to point out truthfully the attempts made and their results. My first object is to show that the operation is both easy and harmless, and I have therefore strongly insisted on the mildness of the inflammatory action after this amputation, and the benefit experienced along with freedom from danger. It is a

sine quâ non now that any operation should be harmless in itself, the object of which is to protect the woman from those dangers which are incidental to uterine deviations, and the aim of the minute examination we have given to this question, is to guard her against the rash experiments to which she has too often fallen a victim. We shall be well rewarded if our toil happily results in proving of use to that class of patients in whom we have been so constantly interested.

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LIST OF REFERENCES TO AUTHORS.

- Albers de Bresme. Case of intra pelvic hæmorrhage, from rupture of tubal pregnancy i., 245
 Extrait de Dezeimeris. Grossesses extra-utérines. (Journal des connaissances médico-chirurgicales, t. iv., p. 240.)
- „ Case of tubo-interstitial pregnancy i., 253
 Ibid t. ix., p. 243.
- Ameline. Essai sur l'antéversion de l'utérus. Paris, 1827.
 „ Thèse, Paris, 1827.
- Amussat. Case of menstrual retention, from absence of the vagina .. i., 15
 (Gaz. Med. 1835, p. 785 and 817.)
- „ Operation for menstrual retention i., 134
- Andral. Case of purulent pelvi-peritonitis ii., 27
 „ Clinique Médicale, t. ii., p. 187.
- Aran. Case of pelvic-hæmatocele (*note*) i., 219
 Leçons clinique sur les maladies de l'utérus 3^e partée, p. 769.
- „ Case of chronic ovaritis and pelvi-peritonitis (*note*) ii., 96
 Ibid, p. 667.
- „ Case of pelvi-peritonitis (*note*) ii., 96
 Ibid, p. 606.
- „ Case of pelvic abscess (*note*) ii., 114
 Ibid, p. 663.
- „ Case of pelvi-peritonitis (*note*) ii., 116
 Ibid, p. 642.
- „ Case of chronic pelvi-peritonitis (*note*) ii., 161
 Ibid, p. 647.
- „ Statistics of flexion in multiparæ ii., 169
 Archives générales de médecine, année, 1858, t. i., p. 313.
- „ Autopsies faites à l'hôpital des enfants, 1854.
- Barlow. Case of hæmorrhage from rupture of the Fallopian tube .. i., 209
 The London and Edinburgh Monthly Journal, x. 1841, p. 877.
- Baudelocque. Case of pelvic abscess (*note*) i., 163
 Journal de Sédillot, t. i., p. 472, 1769-1797.
- „ Case of enormous thrombus (*note*) i., 167
 „ Traité des hæmorrhagies interne de l'utérus. Paris, 1831.
- Becquerel. Traité clinique des maladies de l'utérus et de ses annexes.
 Paris, 1859, t. ii.

- Benevoli. Observations.
- Bernutz. Mémoire sur les accidents produits par la rétention du flux menstruel (Arch. gén. de méd., 1848.)
- Bernutz and Goupil. Recherches clinique sur les phlegmons peri-uterine. Arch. génér. de méd. 5^e série, t. ix.
- Besnier. Case of menstrual retention from imperforate Fallopian tube i., 63
Bulletins de la société anat. de Paris, 2^e série, t. iii., 1858.
- Bianchi. Case of intra pelvic hæmorrhage (*note*) i., 246
De naturali in humani corpore vitiosa morbosaque generatio, p. 152.
- „ Case of intra pelvic hæmorrhage (*note*) i., 272
Ibid—Historia externa in ovario graviditatis indeque ventralis externa in Taurinensi femina.
- Blot. Thèse de concours de l'agrégation des tumeurs sanguines de la vulve et du vagin pendant la grossesse et l'accouchement. Paris, 1853.
- Boivin, Madame. Case of chronic pelvi-peritonitis (*note*) ii., 123
„ Recherches sur une des causes les plus fréquentes et la moins connue de l'avortement. Paris, 1828.
- „ Case of tubercular pelvi-peritonitis (*note*) ii., 132
Ibid, obs. i., p. 3.
- Boivin et Dugès. Case of dysmenorrhœa from polypus i., 49
Maladies de l'utérus, t. ii. p. 419.
- Bonnemaison. Case of hypertrophy of the cervix (*note*) ii., 214
Huguier, des allongements hypertrophiques du col de l'utérus. Paris, 1860, p. 37.
- Boucher. Case of pelvi-peritonitis (*note*) ii., 140
- Boullard. Thèse de Paris, 1853.
- Bourdon. Case of hæmatocele i., 80
„ Mémoire sur les tumeurs fluctuantes du bassin (Revu. méd. 1841.
- „ Case of hæmatocele i., 81
Loc. cit. p. 81.
- „ Case of suppurative pelvi-peritonitis (*note*) ii., 160
Loc. cit. p. 42.
- Bouvyer. Case of menstrual retention and hæmatocele (*note*) i., 94
Bulletins de la société anatom. de Paris, xxx^e année, 1855, p. 388.
- Boyer. Case of menstrual retention, from congenital atresia of the vagina i., 34
Traité des maladies chirurgicales, 4^e édit., t. x., p. 44.
- Breschet. Mémoire de l'académie des sciences, 1825.
- Bright. Case of extra-uterine pregnancy i., 250
Extraite du journal des connaissances medico-chirurgicales t. v., p. 6.
- Brodie. Case of menstrual retention, from congenital obliteration of the vagina i., 19
Lond. Med. Gaz. vol. xxviii., p. 810.
- Calet. Case of prolapsus uteri (*note*) ii., 238
- Cazalis. Mechanism of the production of prolapsus uteri ii., 217
Legendre. Thèse de concours. De la chute de l'utérus. Paris, 1860, p. 72.

- Cazeaux. Bulletins de l'académie de médecine séance du 28 juin, 1854.
- Charcot. Case of hydatid cyst of the pelvis (*note*) i., 125
Gazette médicale, 1852, p. 540.
- Chassaignac, on *ballotement* in anteversion. Gazette des hôpitaux, 1854.
- Chaussier. Case of menstrual suppression i., 150
Recueil de mémoires, consultation, et rapports sur divers objets de
médecine légale, p. 397. Paris, 1824.
- „ Case of peri-uterine hæmatocele (*note*) i., 163
Ibid.
- Chéreau. Mémoire pour servir à l'histoire des maladies des ovaries.
- Chipault. Case of cancer uteri, and pelvi-peritonitis (*note*) ii., 71
- Chomel. Dictionnaire de médecine, en 30 vols. t. xxiii.
- Churchill. On pelvi-peritonitis after delivery, Dublin Journal of Medi-
cine, 1844, vol. xxiv.
- Cossy. Mémoire sur une cause peu connue d'engorgement interne de
l'intestine. Mémoires de la société d'observation, 1856.
- Cusco. Thèse pour le concours de l'agrégation, 1853.
- Dalmas. Case of pelvi-peritonitis (*note*) ii., 105
Journal hebdomadaire, 1828, t. i., p. 114.
- Dance. Case of menstrual retention from obliteration of the cervix i., 27
Maladies de l'utérus (Arch. gén. de méd., 1^{re} série, t. xx., p. 530
Obs. v.).
- Debrou. Case of menstrual retention, from coarctation of the vagina i., 17
Gaz. Med., 1851, p. 32.
- Décis. Case of menstrual retention, uterus and vagina bifid, part obli-
terated i., 21
Bulletins de la société anatomique de Paris, juillet et août, 1854,
p. 222.
- Delpèch. Case of menstrual retention, from imperforate labia i., 13
Mémorial des hôpitaux du Midi, 1830, p. 479.
- „ Case of menstrual retention, from imperforate cervix i., 24
Ibid, t. ii., p. 147. Paris, 1830.
- Demarquay. Case of pelvic abscess (*note*) ii., 37
Gazette des hôpitaux, 17 avril, 1858.
- Deneux, sur les tumeurs sanguines de la vulve et du vagin. Paris, 1830.
- Denonvilliers. Case of menstrual retention i., 81
Gazette des hôpitaux, 14 juillet, 1851.
- Depaul. Statistics of flexions of the uterus in nulliparæ ii., 169
Bulletins de l'académie impériale de médecine, 1854, p. 639.
- „ On rupture of veins of the broad ligaments
Bulletins de la société anatom. de Paris, 1847, t. xxii., p. 15.
- Descroizilles. Case of menstrual suppression, from the use of sponge i., 147
Société médicale d'observation, Jan., 1860.
- Désormeaux et P. Dubois "Amenorrhée" dict. de méd., édit. 2^e t. viii.,
p. 361.
- Devalz. Thèse inaug. (Paris, 1858). Du varicocèle ovarien et de son
influence sur le développement de l'hématocèle rëtro-uterine.
- Dezeimeris. Grossesses, extra-uterines. (Journal des connaissances—
médico-chirurgicales, t. v., p. 240.)
- Dreeq. Case of rupture of the ovary i., 184
Journal universel des sciences médicales, 1826, t. xiii., p. 361.

- Dubois. Case of congenital abscess of the vagina i., 133
Boivin et Dugès, loc. cit., t. i., p. 272.
- Dufour. Case of dysmenorrhœa i., 50
Bulletins de la société anatomique de Paris, 1856, xxxi., année,
p. 321.
- Duparquo. Case of menstrual suppression, from fright i., 59
Maladies de la matrice, 2^e. édit., t. i., obs. ii., p. 6.
,, Case of obliteration of the cervix i., 143
Loc. cit., t. ii., p. 14.
- Dupuytren. Leçons orales, t. iii.
- Durand Fardel. Case of prolapsus uteri ii., 210
Bulletins société anatomique, 1838, 13^e année, p. 304.
- Duverney. Case of intra-pelvic hæmorrhage, from rupture of tubal
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Œuvres anatomiques, t. ii., p. 355-6.
,, Case of extra uterine pregnancy i., 270
Loc. cit., t. ii., p. 357.
- Fauvel. Case of menstrual retention from imperforate Fallopian tube. i., 65
Bulletins de la société anatomique de Paris, xxx^e., année, 1855,
p. 393.
- Fenerly. Case of menstrual retention and hæmatocele i., 87
Thèse inaugurale. Paris, 1855, p. 53.
,, Case of intra-pelvic hæmatocele i., 89
Loc. cit., p. 56.
,, Case of intra-pelvic hæmorrhage, from ruptured Fallopian tube .. i., 235
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- Ferréol. Case of menstrual retention from contraction of the vagina .. i., 28
- Fleuriot. Case of intra-pelvic hæmorrhage, from ruptured ovarian
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Bulletins de la société anatomique de Paris, 30^e année, 1855,
p. 399.
- Follin. Case of prolapsus uteri, and allongement (*note*) ii., 213
Huguier. Des allongements hypertrophiques du col de l'utérus,
p. 91. Paris, 1860.
- Forget (de Strasbourg). Case of cancer uteri; chronic peritonitis (*note*) ii., 132
Gazette médicale de Paris, 1851, p. 41.
- Frank, J. P. Case of menstrual retention, from adhesion of the cervix
to the vagina i., 25
Obs. de J. P. Frank, t. ii., p. 259, Edit. franç. de Double, 1842.
- Gaillard (de Poitiers), on uterine displacement. Bulletins de l'académie
de méd., 1854.
- Gallard. Theory of extra-uterine ovulation i., 191
Bulletins de la société anatomique, loc. cit.
,, Case of intra-pelvic hæmorrhage i., 255
Loc. cit., année, 1854, p. 390.
,, Case of ante flexion (*note*) ii., 228
Théorie de l'hématocèle (Gaz. hebdomadaire, 1858, p. 461).
- Gariel's pessary ii., 205

- Gaube. Case of tubo-abdominal pregnancy i. 259
 Bulletins de la société anatomique, 28^e année, 1850, p. 120.
- Gibert, on anteversion in multiparæ. Bulletin de l'académie impériale
 de médecine, 1849.
- Godelle. Case of rupture of tubal pregnancy i., 198
 Nouvelle bibliothèque médicale, 1828.
- Gosselin. Case of tubercular pelvi-peritonitis (*note*) ii., 166
 „ Statistics of flexion of the uterus ii., 171
 Bulletins de l'académie impériale de médecine, 1854, p. 639.
- Goupil. Case of menstrual retention from gangrene of the vagina
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 Bulletins de la société d'observation décembre, 1856.
- Grandcollot. Description of pessary ii., 127
- Grisolle. Histoire des tumeurs phlegmoneuses de la fosse iliaque (Arch.
 gén. de méd. 3^e série t. iv., 1839.)
- Haen De. Case of menstrual retention from imperforate hymen .. i., 13
 Obs. de De Haen. Ratio medendi, part vi., t. iii., p. 38. Didot,
 1764.
 „ Case of menstrual retention from absence of the vagina .. i., 16
 Loc. cit., part vi., vol. iif., p. 32.
- Haller. Elementa physiologiæ, t. vii., liv. 28, § 31, 2^e édit. Lausaune,
 1778.
- Harrison. Case of pelvi-peritonitis (*note*) ii., 26
 Amer. Jour. of the Med. Sci., February, 1835, p. 372.
- Herpin (De Genève). On prolapsus uteri. Société médicale d'observa-
 tion, année, 1854.
 Thèse de M. Voisin. Obs. xi., p. 116.
- „ Case of hæmatocele i., 221
 Loc. cit., obs. i., p. 111.
- Hervez de Chégoïn. Case of menstrual retention from absence of
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 Arch. gén. de médecine, 1^{re} série, t. xxi., p. 610.
- „ Description of pessary ii., 235
- Heurteaux. Case of hæmatocele (*note*) i., 212
- Hippocrates. Traduction de Littré, t. vii.
- Hoffmann. Opusc. pathol. prat.
- Hufeland. Case of sudden death during menstruation i., 183
 Extrait Steinckuchl. Bibliothèque médicale, t. clxx., p. 250. And
 Andral, clinique médicale, t. v., p. 242.
- Huguier. Case of pelvi-peritonitis (*note*) ii., 72
 Des allongements hypertrophiques du col de l'utérus, p. 91.
 Paris, 1860.
- „ Case of procidentia uteri (*note*) ii., 207
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- „ Case of sub-vaginal cervical allongement (*note*) ii., 213
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- „ Case of prolapsus uteri and sub-vaginal hypertrophic cervical al-
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- „ Case of hypertrophic allongement of the uterus (*note*) ii., 220
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- „ Case of prolapsus uteri and hypertrophic allongement (*note*) .. ii., 223
 Loc. cit., obs. xiii., p. 105.
- „ Case of hypertrophic allongement of the uterus (*note*) ii., 242.
 Loc. cit., p. 195.
- Jacquemier. Manuel des accouchements, t. i., p. 373.
- „ Recherches d'anatomie, &c., sur l'utérus humain pendant la
 gestation, pour servir à l'histoire des hémorrhagies utérine.
 Arch. gén. de méd. 3^e série, t. v., p. 323.
- Jarjarvay. Anatomique chirurgicale, t. ii.
- Jourel. Case of menstrual suppression i., 106
 Bulletins de la Faculté de Médecine de Paris. No. 8, 1812.
- Köner. Case of intra-pelvic hæmorrhage (*note*) i., 246
 Extrait de Moreau, op. cit., p. 19.
- Lachapelle, Madame. Case of extra-uterine pregnancy i., 247
 Pratique des accouchements, t. iii., p. 147.
- Lailler. Case of retroflexion (*note*) ii., 204
- Latour (D'Orleans). Case of menstrual retention from obliteration of
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 Extraite de Duparque maladies de la matrice, t. ii., p. 13.
- Laugier. Theory of hæmatocele from rupture of the ovary i., 181
 Comptes rendus des séances de l'académie des sciences, février,
 1855, t. xl., p. 558.
- Le Chaptois. Case of hæmorrhage from the abdominal peritoneum
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 Archiv. gén. de médecine. 3^e série, t. v., p. 230.
- Leclerc. Case of vascular tumour of the broad ligament i., 169
 Arch. génér de méd. 1^{re} série, 1828, t. 18, p. 281.
- Legendre. Thèse de concours. De la chute de l'utérus. Paris, 1860.
- Lenoir. Theory of the formation of hæmatocele (*note*) i., 190
 Séance de la Société de chirurgie, du 4 juin, 1851.
- Le registre des autopsies faites en 1853, a la maternité.
- Letallier. Des metrorrhagies symptomatiques. Thèse, Paris, 1858.
- Levret, on elongation of the supra-vaginal portion of the cervix.
 Journal de médecine, de chirurgie et de pharmacie, par a Roux,
 1775.
- Littré. Case of menstrual retention, from partial obliteration of the
 cervix i., 36
 Histoire de l'acad. royale des sciences (obs. xiii., p. 27), 1704.
- „ Case of intra-pelvic hæmorrhage, from rupture of tubal pregnancy i., 243
 Mémoire de l'acad. des sciences, année, 1702, p. 209.

- Locatelli. Case of menstrual retention, from congenital imperforation of the vagina i., 19
Gazzetta medica di Milano, cité dans l'Encyclographie belge, 9^e série, t. i., p. 268 (Bruxelles, 1848).
- Lorain. Statistics of uterine flexions in the newly born ii., 169
 „ *Thèse inaugurale*. Paris, 1855.
- Luton. Case of intra-pelvic hæmorrhage, from the ovary i., 186
Gazette médicale, 1856, p. 76.
- Malgaigne. Case of metrorrhagia simulating fibrous tumour (*note*) .. i., 117
Vigués. *Thèse*. Paris, 1850, p. 21.
- Marchal (de Calvi). *Thèse d'agrégation*. Paris, 1844.
- Marchand et Masse. Case of menstrual retention, from imperforate hymen (*note*) i., 14
Journal de médecine de la Loire inférieure, t. xxvi., 131^e et 132^e livraison.
- Marotte. De quelques épiphénomènes des neuralgies lombo-sacrées pouvant simuler des affections idiopathiques, de l'utérus et de ses annexes (*Arch. de méd.*, 1860).
- Martin, le Jeune. Case of retroversion (*note*) ii., 186
Mémoires de médecine, et de chirurgie pratique. Paris, 1835, obs. iv., p. 146.
- Mauriceau. *Des maladies des femmes grosses*, 5^e édit., t. i., p. 86.
 „ Case of retroversion ii., 186
Ibid., obs. xv., p. 166.
 „ Case of retroversion and retroflexion (*note*) ii., 203
Ibid., obs. xxii., p. 174.
- Menière. Case of tubercular menstrual retention, from obliteration of the Fallopian tube i., 169
- Munck. *London Medical Gazette*, vol. xxvii., p. 867.
- Moslin. *De mulierum passionibus liber*, traduction latine de O. Dewez. Vienna, 1793.
- Mussy, Noel Gueneau de. Case of pelvi-peritonitis (*note*) ii., 76
Moniteur des hôpitaux, 1854, p. 56.
- Nélaton. *Elements de pathologie chirurgicale*, t. v., p. 220. Paris, 1859.
 „ *Leçons orales sur l'hématocèle faites à l'hôpital des cliniques et recueillies*, par MM. Bouchet et Gaillet.
 „ Case of suppurative pelvi-peritonitis i., 85
A. Voisin. *Thèse inaugurale*, 1858, p. 52.
- Neuman. Case of rupture of the ovary (*note*) i., 184
Bibliothèque médicale de Royer—Collard, t. lxxviii, p. 113.
- Nonat's. Criticism of pelvic hæmatocèle refuted i., 203
 „ *Traité pratique des maladies de l'utérus*, p. 356. Paris, 1860.
 „ Case of pelvi-peritonitis ii., 17
Loc. cit.
 „ Case of peri-uterine phlegmon (*note*) ii., 145
Loc. cit., obs. xviii., p. 783.

- Notta. Case of prolapsus uteri (*note*) ii., 221
 Bulletin de la société anatomique, année, 1848, p. 174.
- Oldham. Case of dysmenorrhœa, from strictured cervix uteri .. i., 36
 London Medical Gazette, 1846, vol. ii., p. 909.
 „ Case of mechanical dysmenorrhœa i., 37
 Loc. cit., obs. 1, p. 920.
 „ Case of pseudo-membranous dysmenorrhœa i., 51
 Loc. cit., p. 970.
 „ Case of pelvi-peritonitis ii., 76
- Ollivier (d'Angers). Case of rupture of the pampiniform plexus .. i., 169.
 Arch. gén. de méd., 2e série, 1834, t. v., p. 403.
 „ Case of tubal pregnancy, rupture of ovarian veins i., 236
 Ibid.
- Oulmont. Bulletins de la société médicale des hôpitaux de Paris, 1859, t. v., No. 1, p. 36.
- Paget. Case of menstrual retention, from imperforate hymen .. i., 14
 Brit. med. jour., July 23, 1859. Case 1.
- Panck. Case of sudden death during menstruation (*note*) i., 1
 Entdeckung der organischen Verbindung zwischen Tuba und Eirstock beim menschlichen Weibebalch nach der conception. Dorpat, Leipzig, 1843.
- Pauly. Case of menstrual retention, from occlusion of the os uteri .. i., 27
 Maladies de l'utérus; d'après les leçons de Lisfranc, p. 230. Paris, 1836.
 „ Case of rupture of the Fallopian tube i., 196
 Gazette des hôpitaux, 1847, p. 155.
- Payan. Case of intra-pelvic hæmorrhage from extra-uterine pregnancy i., 241
 Bulletin de l'académie de médecine, 1843.
- Pelletan. Case of intra-pelvic hæmorrhage from ruptured ovarian varices i., 183
 Clinique chirurgicale, t. ii., p. 106. Paris, 1810.
- Piachaud. Case of anteversion of the uterus (*note*) ii., 174
 Thèse, Paris, 1852, obs. ii., p. 68.
 „ Case of anteversion (*note*) ii., 180
 Loc. cit., p. 63.
 „ Case of anteflexion (*note*) ii., 198
 Loc. cit., p. 74, obs. vi.
- Pize. Case of extra-uterine pregnancy i., 258
 Bulletins de la Société anatomique, année, 1853, p. 40.
- Pointe. Case of prolapsus uteri (*note*) ii., 211
 Journal de médecine et de chirurgie, t. lxxxv., p. 302, année, 1823.
- Pollard. Case of tubal pregnancy; apoplexy of the ovary (*note*) .. i., 189
 Lancet, March, 1848.
- Postello. Eruditorum, t. iii. Leipzig, 1862.
- Prost. Case of hæmatocele (*note*) i., 182
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 „ Case of abortion (*note*) i., 204
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- Puech. Case of sudden death during menstruation i., 2
 De l'hématocèle peri-utérine et de ses annexes, obs. xviii., p. 17.
 Montpellier, 1858.
 „ Case of menstrual suppression from mental emotion i., 187
 Loc. cit., obs. viii., p. 29.
- Reynaud. Case of tuberculosis of the generative organs (*note*) ii., 126
 De l'affection tuberculeuse de l'utérus. (Arch. génér. de
 méd. 1^{re} série, t. xxvi., p. 487.)
- Richet. Case of utero-ovarian varix (*note*) i., 177
 Traité d'anatomie médico-chirurgicale, p. 735. 2^e édit. Paris,
 p. 367.
- Rochoux. On orchitis ii., 1
 Arch. gén. de méd. 2^e série, 1833., t. ii., p. 51.
- Roser's hysterophor ii., 237
- Rouget. Recherches sur les organes érectiles des femmes, &c.
- Royer (De Joinville). Case of tubal pregnancy (*note*) i., 197
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 „ Case of tubercular disease of the ovaries, &c. (*note*) ii., 126
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- Ruysch. Case of menstrual retention from imperforate vulva i., 13
 Observationum Anatomico-chirurgicarum centuria, obs. xxxii.,
 p. 42., 1691.
 „ Case of sterility from obstructed Fallopian tube i., 191
 Loc. cit., obs. lxxxiii., édit. d'Amsterdam, 1691.
- Sabatier. Case of intra-pelvic hæmorrhage from rupture of tubal
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 Médecine opératoire. 2^e édit., t. iii., p. 279.
- Saint Moressy. Case of ovarian pregnancy i., 249
 Duvernoy, Œuvres anatomiques. Paris, 1761, t. ii., 351.
- Satis. Case of menstrual retention and hæmatocele i., 90
 Thèse inaugurale, p. 89, Paris, 1847.
 „ Case of recurring menstrual suppression i., 96
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- Scanzoni. Case of hæmorrhage from the Fallopian tube i., 208
 Hæmorrhagies dans le canal des trompes, p. 312. Paris, 1858.
 „ Modification of Roser's hysterophor ii., 239
- Silvestre. Case of pelvic hæmatocele i., 222
 Thèse de M. Voisin, obs. viii., p. 98.
- Simon. Case of peri-uterine abscess (*note*) ii., 37
 Bulletins de la société anatomique de Paris, xxxiii., année, 2^e
 série, t. iii., mai, juin, 1858, No. 20, p. 23-4.
- Simpson (Sir James). Edin. Monthly Journal, Sept. 1846, p. 161.
- Siredey. Case of intra-pelvic hæmorrhage from tubal pregnancy i., 251
 Thèse inaugurale. Paris, 1860, p. 98.
 „ Case of chronic pelvi-peritonitis (*note*) ii., 97
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- „ Case of tubercular peritonitis (*note*) ii., 125
 Loc. cit. obs. vi., p. 110.
- Stahelin et Haller, vide Haller loc. cit.
- Stoltz. Case of menstrual suppression and hæmatocele (*note*) .. i., 116
 Thèse de M. Engelhard, Strasbourg, 1856, No. 364, p. 35.
- Switzer. Case of tubal pregnancy i., 196
 Tilt. On ovarian inflammation, case 73, p. 58.
- Schuh. Wochenblatt der Zeitschrift der Gesellschaft der Aerzte zu wien,
 No. 31, 1857.
- Schurgius. Muliebria historico-medica, sect. 3, ch. iv. De tubis Fallo-
 pianis, p. 380, Dresde et Leipzig, 1779.
- Tardieu. Case of hæmorrhage from the pelvic-peritoneum i., 176
 Annales d'hygiène publique, juillet, 1854, 2^e série, t. ii., p. 157.
- Tarnier. Case of puerperal fever (*note*) ii., 109
 Thèse inaugurale. Paris, 1857, p. 60.
- Tilt. Case of rupture of aneurism of the iliac artery i., 180
 On ovarian inflammation. p. 262, 2^e édit., 1853.
 “ Case of dysmenorrhœa and hæmatocele (*note*) i., 206
 Loc. cit. p. 261.
- Trousseau. Theory of the formation of hæmatocele i., 208
 Gazette des hôpitaux, 22 et 29 juin, 1858, pp. 285, 298.
 „ Case of hæmatocele i., 208
 Ibid.
- Trousseau et Pidoux. Traité de Thérapeutique.
- Ucelli. Case of ovarian pregnancy i., 249
 Bibliothèque médicale t. xxxviii., p. 265.
- Valleix. Case of ante- and latero-version (*note*) ii., 180
 Leçons sur les déviations utérine, 1852, p. 54.
 „ Case of retroflexion (*note*) ii., 201
 Loc. cit. p. 122.
- Velpeau. Case of menstrual retention and hæmatocele i., 88
 Recherches anatomiques, &c., sur les cavités closes (Annales de
 la chirurgie française et étrangère. Paris, 1843, t. vii., p. 430.)
- Vieuses. Case of pelvi-peritonitis (*note*) ii., 114
 Delaroché, Fievre puerperale, p. 288. Paris, 1783.
- Viguès. Case of hæmatocele i., 217
 Thèse inaugurale, p. 49. Paris, 1850.
 „ Case of pelvic hæmatocele i., 224
 Loc. cit. p. 7, obs. ii.
- Voisin. Case of menstrual retention and formation of hæmatocele .. i., 105
 Thèse inaugurale. Paris, 1858, p. 59.
 „ Case of menstrual suppression and formation of hæmatocele .. i., 217
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| Wuillaume. | Case of absence of the vagina, Gazette Médicale, 1835, | | | | | | | |
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REPORT

PRESENTED TO THE EIGHTH ANNUAL MEETING; HELD
AT CHESTER, AUGUST 10TH, 1866.

With the present year the New Sydenham Society may be considered to commence an almost wholly New Series of publications. The Atlas of Skin Diseases presents the only exception to this statement. With regard to this work the Council has determined to publish a Fasciculus regularly each year, and hopes to be able to conclude it in five years.

The present year seemed to offer a good opportunity for extra effort to increase the Society's Members, and accordingly, both by the distribution of printed statements and by advertisements, the Council has endeavoured to diffuse widely a knowledge of the advantages which it affords. The result has been a very considerable gain to the Members' list. It is hoped that during the remaining half of the year still further additions will be made, and the Council solicits the zealous co-operation of the Members generally to this object.

The four following works will constitute the series for the current year:—

I.

BERNUTZ AND GOUPIL'S TREATISE ON DISEASES OF WOMEN.

Translated and abridged by Dr. MEADOWS. Vol. I.

II.

HEBRA ON EXANTHEMS AND DISEASES OF THE SKIN. Vol. I.

Translated by Dr. HILTON FAGGE.

III.

THE SOCIETY'S ATLAS OF SKIN DISEASES.

A SIXTH FASCICULUS, to comprise (in three Plates) Illustrations of—

Eczema Impetiginoides on Face of Adult. Eczema on the Face, &c., of Infant. Eczema Rubrum on Leg of Adult. Psoriasis of Hands and Finger-Nails. Syphilitic Psoriasis of Finger-Nails. Congenito-Syphilitic Psoriasis of Finger and Toe-Nails. Onychia Maligna. Chronic General Onychitis.

IV.

BERNUTZ AND GOUPIL'S TREATISE ON DISEASES OF WOMEN.

Vol. II. Translated by Dr. MEADOWS.

In volume 28 (Bernutz and Goupil) the experiment has been tried of abbreviating the text of the original, and a volume of 590 pages has been condensed into one of 276. It is hoped that this has been done without any material loss to the usefulness of the work, whilst it has of course permitted a very great reduction in its cost. The Council is of opinion that from time to time other valuable foreign works of such large size as to render their translation *in extenso* inexpedient, if not wholly impracticable, may with great advantage be thus introduced to the English profession.

It is not of course intended to contrast the value of a condensed translation with that of a complete one, but it is to be remembered that instead of the full translation of one large work, it may be easily practicable to produce abbreviated editions of two or three. Not only is the Council able to secure for the responsible work of condensed translation the services of highly accomplished Editors, but it trusts also, as usual heretofore, to obtain the co-operation of the authors themselves.

The Society's finances, as shown by the Balance-sheet, are at present in a highly satisfactory condition; and after all liabilities for this year's works have been discharged, the Council will be able to carry over a sufficient balance to begin the next year to advantage.

The works which it is proposed to issue during 1867 are the following four:—

I.

A BIENNIAL RETROSPECT OF MEDICINE AND SURGERY. Vol. I.

Physiology, Mr. H. POWER; Medicine, Dr. ANSTIE; Surgery (General), Mr. T. HOLMES; Ophthalmic Medicine and Surgery, Mr. T. WINDSOR; Midwifery, Dr. BARNES; Forensic Medicine, Toxicology and Hygiene, Dr. HILTON FAGGE.

II.

GRIESINGER'S MANUAL OF MENTAL DISEASES.

Translated by Dr. LOCKHART ROBERTSON and Dr. RUTHERFORD.

III.

A SEVENTH FASCICULUS OF THE SOCIETY'S ATLAS OF
PORTRAITS OF SKIN DISEASES.

IV.

HEBRA ON EXANTHEMS AND DISEASES OF THE SKIN. Vol. II.

Translated by Dr. HILTON FAGGE and Dr. PYE SMITH.

In concluding this Report, the Council earnestly invites the attention of the Members to the fact that the Society's interests are really in their own hands, and asks for their active co-operation. The Council has done its utmost to economise the expenditure of the Society's funds, and to direct them into channels likely to meet the wants of the profession, and to assist the advancement of Medical and Surgical Science.*

* In addition to the works mentioned above, the first part of a letter-press Companion to the Atlas of Portraits of Skin Diseases will also be published during the current year.

L A W S

OF THE NEW SYDENHAM SOCIETY.

I. The Society is instituted for the purpose of supplying certain acknowledged deficiencies in the existing means of diffusing medical literature, and shall be called *The New Sydenham Society*.

II. The Society shall carry out its objects by a succession of publications, of which the following shall be the chief:—1. Translations of Foreign Works, Papers, and Essays of merit, to be reproduced as early as practicable after their original issue: 2. British Works, Papers, Lectures, &c., which, whilst of great value, have become from any cause difficult to be obtained, excluding those of living authors: 3. Annual Volumes consisting of Reports in abstract of the progress of the different branches of Medical and Surgical Science during the year: 4. Dictionaries of Medical Bibliography and Biography. Those included under Nos 1 and 2 shall be held to have the first claim on the attention of the Society, and the carrying out of those under 3 and 4 shall be considered dependent upon the amount of funds which may be placed at its disposal.

III. The subscription constituting a Member shall be One Guinea, to be paid *in advance* on the 1st of January annually, and it shall entitle the subscriber to a copy of every work published for that year. *No books shall be issued to any Member until his subscription for the year has been paid.*

IV. The officers of the Society shall be elected from the Members, and shall consist of a President, Sixteen Vice-Presidents, a Treasurer, a Secretary, and a Council of Thirty-two; in whom the power of framing bye-laws, and of directing the affairs of the Society, shall be vested. Twelve of the Council shall be Provincial Residents.

V. Five Members of the Council shall form a quorum.

VI. The Officers of the Society shall be elected by ballot at the General Anniversary Meeting of the Society. Balloting Lists of Officers proposed by the Council, with blank places for such alterations as any Member may wish to make, shall be laid on the Society's table for the use of Members.

VII. The President, Vice-Presidents, and Council, shall be eligible for re-election, except that of the Vice-Presidents four, and of the Council eight, shall retire every year.

VIII. The Council shall appoint Local Honorary Secretaries wherever they shall see fit.

IX. The business of the President shall be to preside at the Annual and Extraordinary Meetings of the Society; in his absence one of the Vice-Presidents, or the Treasurer, or any Member of the Council chosen by the Members present, shall take the chair.

X. The Treasurer, or some person appointed by him, shall receive all moneys due to the Society.

XI. The money in the hands of the Treasurer, which shall not be immediately required for the uses of the Society, shall be vested in such speedily available securities as shall be approved of by the Council.

XII. The Council shall select the Works to be published by the Society, and shall make all arrangements, pecuniary or otherwise, in regard to their publication. In the event of any Member of the Council being appointed to edit any work for the Society, for which he is to receive pecuniary remuneration, he shall immediately cease to be a Member of the Council, and shall not be eligible for re-election till after the publication of the work.

XIII. The Council shall lay before the Members at each Anniversary Meeting a report of their proceedings during the past year, and also an account of the receipts and expenditure of the Society; and shall further cause to be printed, and circulated among the Members, an Abstract of such Report and Accounts immediately after such Anniversary Meeting.

XIV. The annual accounts of the receipts and expenditure of the Society shall be audited by a Committee of three Members, selected at the preceding Anniversary Meeting from among the Members at large.

XV. The Secretary shall have the management of the general correspondence of the Society, and of such other business as may arise in carrying out its objects.

XVI. The Local Secretaries shall further the objects of the Society in their respective districts, and shall be in communication with the Metropolitan Secretary.

XVII. The Anniversary Meeting shall be held in the same town as, and at the time of, the Annual Meeting of the British Medical Association, notice of it having been given to all Members at least a week before the day fixed on.

XVIII. The Members generally shall be invited and encouraged to propose Works, &c., and to make any suggestions to the Council they may think likely to be useful.

XIX. The Works of the Society shall be printed for the Members only.

XX. No alteration in the Laws of the Society shall be made, except at a General Meeting. Notice of the alteration to be proposed must also have been laid before the Council at least a month previously.

XXI. The Council shall have power to call a General Meeting of the Members at any time, and shall also be required to do so within three weeks, upon receiving a requisition in writing to that effect from not less than twenty Members of the Society.

XXII. All Special General Meetings of the Society shall be held at such place as the Council may appoint.

XXIII. The council shall meet at least once in two months, unless by special resolution to the contrary.

A THIRD EDITION of the Volumes for 1859 has been printed, and also a Second Edition of those for 1860. All the Works issued by the Society are now in stock, and can be obtained by New Members.

CARRIAGE, &c.—The Society's Works are supplied free of cost to any address in London, Edinburgh, or Dublin; but the expense of carriage to all other places must be borne by the Members to whom they are sent. Members wishing to receive their Volumes by Book-post can do so by prepaying the postage. Members are requested to give detailed instructions respecting the mode by which they wish their volumes to be forwarded, and also to remember that the Society's responsibility ceases when the book has been delivered according to the instructions given.

The Subscription is One Guinea annually, to be paid *in advance*. The best mode of sending money is by post-office order, payable to Mr. HENRY KING LEWIS, at the London Office, or by cheque to the order of the Treasurer, Dr. SEDGWICK SAUNDERS. It is requested that in future all communications in reference to the payment of subscriptions, or the issue of books, may be made to Mr. LEWIS, the Society's Agent, and not as heretofore to the Secretary.

There are yet many important districts in which the Society is unrepresented. The Council will be glad to make appointments of gentlemen inclined to act as Local Secretaries in them. A list of these places may be had on application to Mr. HUTCHINSON.

P.S.—The Society's Agent is prepared to supply PORTFOLIOS for the reception of the Plates of Skin Diseases to those Members who may wish for them:—First quality, 10*s.*; Second quality, 5*s.* 6*d.*; Third quality (cloth only), 3*s.* 6*d.* All orders for them must be accompanied by the remittance and instructions as to mode of transmission.

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- b. On the Breast of the Child's Mother.
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THE FOURTH FASCICULUS OF THE ATLAS OF
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COMPRISING ORIGINAL PLATES, ILLUSTRATING:—

PLATE X. MORBUS ADDISONII. PLATE XI. LEUCODERMA.

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THE FIFTH FASCICULUS OF THE ATLAS OF
PORTRAITS OF SKIN DISEASES,

COMPRISING ORIGINAL PLATES, ILLUSTRATING:—

PLATE XII. PEMPHIGUS. PLATE XIII. PITYRIASIS VERSICOLOR.
PLATE XIV. PSORIASIS INVETERATA.

CLINICAL MEMOIRS ON DISEASES OF WOMEN.

BY DRS. BERNUTZ AND GOUPIL.

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“With these remarks we recommend this volume to the notice of our readers. The careful study of the three valuable memoirs which it contains, is imperative on all who are interested in gynecology, partly because the essays contain a notice of all that is at present known of the subjects to which they are devoted, but, still more for the reason that they are eminently suggestive in indicating the starting-point for further inquiries.”—*Lancet*, *October 27th*, 1866.

THE SIXTH FASCICULUS OF THE ATLAS OF
PORTRAITS OF SKIN DISEASES,

COMPRISING ORIGINAL PORTRAITS ILLUSTRATING :—

Plate XV. Eczema Impetiginoides on Face of Adult.

Plate XVI. Eczema on the Face, &c., of Infant; Eczema Rubrum on Leg of Adult.

Plate XVII. Psoriasis of Hands and Finger-Nails; Syphilitic Psoriasis of Finger-Nails; Congenito-Syphilitic Psoriasis of Finger- and Toe-Nails; Onychia Maligna; Chronic General Onychitis.

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BY DRS. BERNUTZ AND GOUPIL.

VOL. II. TRANSLATED AND ABRIDGED BY DR. MEADOWS.

This Volume concludes the work, it is the last of the series for 1866.

CONTENTS OF THE ATLAS OF SKIN DISEASES.

The following Diseases of the Skin have received illustration in the plates already published.

Eczema impetiginoides.
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Psoriasis palmaris et manuum.
Psoriasis vulgaris.
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and toe-nails.
Syphilitic psoriasis of nails.
Onychia maligna.
Chronic onychitis.
Morbus Addisonii
Leucoderma.

Lupus exulcerans.
Lupus vulgaris et serpiginosus.
Lupus serpiginosus.
Herpes zoster frontalis.
Molluscum contagiosum on face of child.
Molluscum contagiosum on female breast.
Molluscum contagiosum, anatomy and
microscopic structure of.
Ichthyosis.
Alopecia areata.
Favus.
Favus with tinea tonsurans.
Tinea tonsurans.

The following are in the artist's hands for the next fasciculus.

Psoriasis—Lupus.
Contagious Porrigo.

Molluscum simplex seu fibrosum.

The six fasciculi already out may be obtained separately from the printed works of the Society, at the price of half-a-guinea each. The first part of a letter-press Companion to the Atlas will be published during the present year.

LIST OF WORKS

ARRANGED ACCORDING TO THE YEARS IN WHICH
ISSUED.

All the published Works are now in Stock, and can be obtained by New Subscribers. Subscription for full sets, Eight Guineas. The Works for any single year can be obtained if desired.

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“Of the judicious selection and practical value of the Treatises published by the Society there cannot be the least doubt.”—*Lancet*, September, 1863.

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GRIESINGER'S MANUAL OF MENTAL DISEASES.

HEBRA ON EXANTHEMS AND DISEASES OF THE SKIN.

A BIENNIAL RETROSPECT OF MEDICINE AND SURGERY,
FOR 1865-66.

A SEVENTH FASCICULUS OF THE ATLAS OF PORTRAITS
OF SKIN DISEASES.

